Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 3 April 2025** at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams (HYBRID).

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.01	**2**	**REGISTER OF INTERESTS**	Chair	*Appendix-2025-13*
10.02	**3**	**MINUTES OF PREVIOUS MEETING** 06.02.25	Chair	*Attached*
10.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
10.05	**5**	**CHIEF EXECUTIVE'S REPORT**	Chief Executive	*Appendix-2025-14*
10.10	**6**	**STRATEGY**		
10.10	6.1	Health Board Collaboration and Leadership	Chief Executive	*Appendix-2025-15*
10.15	6.2	Developing NHS Borders Strategy	Chief Executive	*Appendix-2025-16*
10.20	6.3	Pharmaceutical Care Services Report Update	Director of Pharmacy	*Appendix-2025-17*
10.25	6.4	Risk Appetite Policy	Director of Quality & Improvement	*Appendix-2025-18*
10.30	**7**	**FINANCE AND RISK ASSURANCE**		
10.30	7.1	Resources & Performance Committee minutes: 16.01.25	Board Secretary	*Appendix-2025-19*
10.31	7.2	Audit & Risk Committee minutes: 16.12.24	Board Secretary	*Appendix-2025-20*
10.32	7.3	Endowment Fund Board of Trustees minutes: 07.10.24, 25.11.24	Board Secretary	*Appendix-2025-21*
10.33	7.4	Finance Report	Director of Finance	*Appendix-2025-22*
10.38	7.5	Financial Plan 2025/26	Director of Finance	*Appendix-2025-23 To Follow*
10.52	7.6	Provision of Resources to the Scottish Borders Integrated Joint Board	Director of Finance	*Appendix-2025-24*

10.55	**8**	**QUALITY AND SAFETY ASSURANCE**		
10.55	8.1	Clinical Governance Committee minutes: 15.01.25	Board Secretary	*Appendix-2025-25*
10.56	8.2	Quality & Clinical Governance Report	Director of Quality & Improvement	*Appendix-2025-26*
11.05	8.3	Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	*Appendix-2025-27*
11.15	**9**	**ENGAGEMENT**		
11.15	9.1	Equalities Mainstreaming Report 2025	Director of Public Health	*Appendix-2025-28*
11.30	9.2	The Logie Legacy	Chair Logie Legacy	*Presentation*
11.45	**10**	**PERFORMANCE ASSURANCE**		
11.45	10.1	NHS Borders Performance Scorecard	Director of Planning & Performance	*Appendix-2025-29*
11.57	**11**	**GOVERNANCE**		
11.57	11.1	Scottish Borders Health & Social Care Integration Joint Board minutes: 20.11.24, 22.01.25	Board Secretary	*Appendix-2025-30*
11.58	11.2	Board Committee Memberships	Chair	*Appendix-2025-31*
11.59	**12**	**ANY OTHER BUSINESS**		
12.00	**13**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 26 June 2025 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams (HYBRID)	Chair	*Verbal*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
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 Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	none
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	none
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	none
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	none
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	none
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	none
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	none

Signed……Karen Hamilton…….. Date …19-02-2025……...

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 MARY SANDFORD…. *(please insert your full name in capital letters)*

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

Signed…… Fiona Sandford …….. Date …26.iii.2025……...

Borders NHS Board

Register of Interests of Board Members

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

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

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	—
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	—
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	—
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	—
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	—
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	—
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	My daughter has been successful in applying for a course for young people in the Scottish Borders who want to work in Health and Social Care. This is a Kings Trust programme in partnership with NHS Borders .On this programme she will receive training and a placement with NHS Borders over the course of four/five weeks commencing in March 25. Lunches and travel will be provided. There is an interview at the end of the programme with an opportunity for employment.

Signed..... Date 23/02/25

Borders NHS Board

Register of Interests of Board Members

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

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

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

Signed…….. Date ……...

Borders NHS Board

Register of Interests of Board Members

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

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

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

Signed David Parker Date 7 March 2025

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 Livesey..... *(please insert your full name in capital letters)*

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

Signed..... Date 21 March 2025.....

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: ……Peter Moore…….. *(please insert your full name in capital letters)*

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

Signed…… …….. Date …21.02.25……...

Borders NHS Board

Register of Interests of Board Members

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

Board Member: ANDREW STEPHEN BONE

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

Signed …….. …… Date ……13th February 2025……...

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: LYNN MCCALLUM ..... *(please insert your full name in capital letters)*

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

Signed..... Date 13/3/25

Borders NHS Board

Register of Interests of Board Members

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

Board Member: SARAH HORAN

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

Signed 

Date 17 February 2025

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 Bhatti…….. *(please insert your full name in capital letters)*

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

Signed……Sohail Bhatti…….. Date …27/03/25……...

Borders NHS Board

Register of Interests of Board Members

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

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

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

Signed. Date 26/03/2025

Borders NHS Board

Register of Interests of Board Members

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

Board Member: ANDREW CARTER, DIRECTOR OF HR

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

Signed *A.N. Carter* Date 28-March-2025

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: OLIVER BENNETT *(please insert your full name in capital letters)*

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

Signed..... Date 25/2/25.

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

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

Signed…. Date 14/02/2025

Borders NHS Board

Minutes of a meeting of **Borders NHS Board** held on Thursday 6 February 2025 at 10.00am in the Roxburgh Suite, Scottish Borders Council and via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Mrs L O'Leary, Non Executive
Ms L Livesey, Non Executive
Mr J Ayling, Non Executive
Mrs H Campbell, Non Executive
Mr J McLaren, Non Executive
Cllr D Parker, Non Executive
Mr P Moore, Chief Executive
Mr A Bone, Director of Finance
Dr S Bhatti, Director of Public Health
Mrs S Horan, Director of Nursing, Midwifery & AHPs

In Attendance:
Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & Performance
Mr A Carter, Director of HR, OD & OH&S
Mr C Myers, Chief Officer, Health & Social Care
Mr S Whiting, Infection Control Manager
Mrs C Oliver, Head of Communications & Engagement
Ms L Henderson, Communications Officer
Mr P Seeley, Office for Mrs R Hamilton MSP
Mr D Knox, BBC Reporter
Ms L Adams, Public Health Registrar

1. Apologies and Announcements

1.1 Apologies had been received from Dr L McCallum, Medical Director, Mrs L Huckerby, Interim Director of Acute Services and Mrs L Jones, Director of Quality & Improvement.

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

1.3 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** noted there were no verbal declarations.

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting of Borders NHS Board held on 4 December 2024 were approved.

4. Matters Arising

4.1 **Action 2024-4:** Mrs Harriet Campbell commented that an explanation paper was presented to the January Clinical Governance Committee meeting and matters would be picked up under the Quality and Clinical Governance Report item on the agenda. The Board agreed to close the action on the action tracker.

4.2 **Action 2024-5:** The Chair advised that the Chair of the ACF had resigned and an election would be held for a replacement. Mrs Fiona Sandford commented that it was important for the Board to receive a strong voice from independent practitioners particularly GPs.

4.3 **Action 2025-1:** It was noted a discussion would take place under any other business in regard to the Staff Governance Committee. The action would remain live.

4.4 **Action 2025-2:** Mr Chris Myers suggested a joint session be held with members of Borders NHS Board and members of the Integration Joint Board on 19 March 2025.

The **BOARD** agreed to close Action 2024-4.

The **BOARD** noted the Action Tracker.

5. Chief Executives Report

5.1 Mr Andrew Bone provided an update on the Knoll Reinforced Autoclaved Aerated Concrete (RAAC) issue to the Board and highlighted: RAAC present in roof panels in some areas and not others; requirement to vacate the premises to allow remedial works to take place; assessing options for decanting and whether some areas could safely remain operational; options for off site services being reviewed; 2 GP practices involved; business continuity plans stood up; gold, silver, bronze command approach in place; 23 in patient beds affected 8 patients decanted and 15 patients currently awaiting decant moves; target date for decant 14.02.25; initial estimate is 6 months for remedial works to be completed; project manager and quantity surveyor have been appointed to support the estates team; and in dialogue with Scottish Government regarding financial arrangements for the matter.

5.2 Mr Peter Moore thanked colleagues, Scottish Government and Scottish Borders Council for their help and support in progressing the matter at pace to ensure the safety of patients and staff remained paramount.

5.3 Mrs Fiona Sandford enquired about the arrangements for decanting inpatients and the impact of delayed discharges on the process. Mr Bone advised that there were 3 workstreams taking place: decant of patients; decant of GP practices and services; and expediting delayed discharges from across the system.

5.4 Mrs Sandford challenged that delayed discharges have failed to be reduced significantly across the past 12 months and enquired how they would be expedited effectively. Mr Chris Myers advised that a number of investments had been made into social care capacity and redesign and the benefit of that was now being seen with more care capacity being available which provided extra resilience. The process for each patient and their family was being reviewed to ensure they were discharged to their right pathway destination, which included Home First as well as social care.

5.5 Further discussion highlighted: temporary redeployment of staff from the Knoll to other areas; 90 staff affected; phase 2 survey of Kelso Community Hospital expected to be received in the new few weeks (survey team have confirmed that initial findings indicate no safety issues requiring urgent action); phase 2 of Jedburgh Health Centre survey is to be scheduled; challenges across Scotland with complexity of surveys and availability of the skillset required to undertake them.

5.6 Mr Moore commented that it was a credit to the staff involved at the Knoll that their immediate reaction to the situation was to support their patients and their families and he appreciated the strong community connections.

5.7 Mr Moore commented that at the previous Board meeting winter preparations had been discussed and he reflected that staff had worked tirelessly to step up services ahead of the festive period which had enabled them to both celebrate that period and take some time to rest. Whilst there were pressures in the system they had not been as tight coming into the New Year period as historically forecast and that he reflected was due to the earlier winter planning preparations that had been put in place. Work had continued on the financial position and he expected the organisation to finish the financial year in a stronger position. Finally, he drew the attention of the Board to the conversations that had been taking place with members of the public and staff to formulate the organisations strategy and the 1400 responses that had been received.

5.8 The Chair welcomed the work that had gone into engagement on the strategy and advised that a media release on the Knoll situation would be issued after the meeting.

The **BOARD** noted the update.

6. NHS Borders Future Direction Engagement Phase 1

6.1 Mrs June Smyth provided an overview of the content of the report and highlighted: the draft strategy; analysis to date and feedback to the population; increased number of feedback received since the paper was issued and the engagement process closed on 31.01.25; thanks to the public who took the time to engage and the rich amount of information received; and the proposed continued engagement with targeted groups.

6.2 Dr Sohail Bhatti commended the team on the extensive engagement that had taken place and recognised it as a firm foundation on which the organisation could move ahead.

6.3 The Chair welcomed the engagement process and the rich amount of information and contacts that had been made and could be potentially utilised in the future. Mrs Smyth confirmed that the questionnaire had been anonymous and contact information was confidential, however there were people who had advised that they would be keen to be involved moving forward.

6.4 The Chair recorded the thanks of the Board to the team.

The **BOARD** noted the report.

The **BOARD** confirmed it had received Significant Assurance from the report.

7. Climate Emergency & Sustainability Annual Report 2023/24

7.1 Mr Andrew Bone provided an overview of the content of the annual report noting that the report was retrospective and that publication was delayed due to availability of national data. Mr Bone summarised the report, noting good progress in some areas including fleet emissions and limited progress in other areas, including energy where increased usage was reflective of clinical service activity and post-COVID remobilisation of services. He highlighted that the objective of delivering net zero by 2040 remained challenging in the context of constrained resources and that a significant factor would be decarbonisation of the national grid, which lay outside of the Health Board's control.

7.2 Mrs Harriet Campbell recorded her thanks to Mr Bone and Mrs Fiona Laidlaw who were fundamental to taking the climate emergency and sustainability agenda forward for the organisation.

7.3 Further discussion focused on: the report could contain more information on the balance of financial sustainability; food waste and how that might be improved; the procurement national framework strategy ensured construction contracts work in line with reducing carbon emissions; capturing number of flights taken and the consequential impact on carbon emissions; capturing commuter miles for staff; and links to the digital strategy.

7.4 Mr Peter Moore welcomed the report and suggested it would be helpful when the organisation moved into the strategic space to consider how the environmental challenge was included in the daily work of the organisation, especially the positive impact of shifting care from the hospital to the community.

7.5 The Chair recorded the thanks of the Board to Mrs Fiona Laidlaw who worked beyond her core remit in regard to climate change.

The **BOARD** approved publication of the annual report in line with the Scottish Government policy requirement.

The **BOARD** confirmed it had received Limited Assurance from the report given the significant challenge presented by achievement of net zero emissions by the target date of 2040 and the lack of resources identified to achieve that objective.

8. Full to the Brim – Director of Public Health Annual Report 2024

8.1 The item was deferred.

9. Resources & Performance Committee minutes: 07.11.24

The **BOARD** noted the minutes.

10. Audit & Risk Committee minutes: 23.09.24

The **BOARD** noted the minutes.

11. Finance Report

11.1 Mr Andrew Bone provided an overview of the report and highlighted that year to date position remained in line with trend and that the forecast outturn was now improved further to reflect this trend, following confirmation of how AFC Reform expenditure would be offset in year. He further highlighted that savings were on trajectory to deliver 3% recurring savings in line with target and that further non-recurring savings were in place to underpin the improved forecast. Despite this Mr Bone reiterated that the pace at which savings were being delivered was slowing and that although this would not impact on current year delivery it continues to present a risk to plans moving forward.

11.2 Mrs Fiona Sandford enquired about the revised annual budget increase and the costs of the additional 22 beds that were opened. Mr Bone commented that the increase referred to non recurring funding streams that were predicted and expected due to policy implementations, such as funding for primary care initiatives and the mental health Action 15 initiative and wider national policy commitments. He further commented that the cost of opening the additional 22 beds was in the region of £2m per year.

11.3 Mr James Ayling enquired if the Knoll costs would be met by the Scottish Government. Mr Bone advised that he had a meeting scheduled with the Scottish Government to discuss the costs associated with the Knoll RAAC.

11.4 Mr Peter Moore commented that the organisation would work over the next few months to provide accountability to the Board on increased productivity alongside financial constraints.

The **BOARD** noted the contents of the report including the following:

YTD Performance	£12.19m overspend
Outturn Forecast at current run rate	£16.25m overspend
M09 Review Forecast (adjusted trend)	£18.64m overspend
Variance against Plan (at current run rate)	£9.51m improvement
Projected Variance against Plan (M09 Forecast)	£2.39m underspend
Actual Savings Delivery (current year effect)	£8.08m (actioned)
Projected gap *to SG brokerage*	Best Case £1.45m (trend) Worst Case £3.84m (M09)

The **BOARD** noted the assumptions made in relation to Scottish Government allocations and other resources.

The **BOARD** confirmed it had received Moderate Assurance from the report.

12. Capital Plan Update

12.1 Mr Andrew Bone provided an overview of the content of the report and drew the attention of the Board to the £2.5m baseline allocation that was fully committed to a rolling programme of maintenance and small works. All Boards were asked to submit draft plans to the Scottish Government for business continuity and maintenance by the end of January. Due to the RAAC issue at the Knoll an extension to end of February for the draft plan had been granted. The final reporting timeline was the end of March which was expected to be achieved. The RAAC issue had now overtaken the aseptic unit as the highest risk in terms of capital expenditure.

The **BOARD** noted the update provided in the paper and recognised the risk in relation to slippage on the programme and the actions in place to mitigate the risk, including further dialogue with the Scottish Government.

The **BOARD** confirmed it had received Moderate Assurance from the report.

13. Internal Audit Contract

13.1 Mr Andrew Bone advised of the process undertaken to award the Internal Audit contract for the new financial year to BDO UK. Mr James Ayling confirmed that as the Chair of the Audit and Risk Committee he was content with the award of the contract to BDO UK.

The **BOARD** noted the process undertaken for appointing the Board's Internal Auditors and formally approved the award of the contract to BDO UK.

The **BOARD** confirmed it had received Significant Assurance from the report.

14. Clinical Governance Committee minutes: 06.11.24

14.1 Mrs Fiona Sandford reported that the Clinical Governance Committee were concerned at the harm being done to those who were not receiving their elective care, especially the long cardiology waits and access to the stroke service.

14.2 Mrs Harriet Campbell advised that both issues had been discussed at the last meeting and reports had been commissioned for the next meeting especially in regard to accessing the stroke unit which appeared to be impacted by delayed discharges.

14.3 Mr Peter Moore advised the Board that the Board Executive Team had been reformatted to focus on 6 key areas of performance on a weekly basis which included waiting times, the non elective pathway, elective waiting times and mental health.

The **BOARD** noted the minutes.

15. Quality & Clinical Governance Report

15.1 Mrs Sarah Horan provided an overview of the content of the report and highlighted several elements including: delayed discharges and impacts on quality of care; risks; cancer prostate biopsies; pressures in psychiatry services; and obstetrics and gynaecology staffing.

15.2 Discussion focused on: delayed discharges and the impact of the delayed discharge daily meeting; implementation of the choices policy; 24% reduction in delayed discharges over the past 90 days; 49% reduction in occupied bed days over the past 90 days; Senior Charge Nurses (SCNs) in key wards are supervisory and are expected to impact positively on safety and quality; and the cross cutting theme of mandatory and statutory training and sickness absence.

The **BOARD** noted the report.

The **BOARD** confirmed it had received Limited Assurance from the report based on the level of assurance taken at the Clinical Governance Committee.

16. Infection Prevention & Control Report

16.1 Mr Sam Whiting provided an overview of the content of the report and highlighted several elements including: benchmarking data of NHS Borders with other Health Boards when national data was published; Quality Improvement activity through audits and spot activity; hand hygiene compliance and short 10 minutes education sessions being held in wards over the next 4 week period; and attendance at the SCNs forum to provide feedback on internal audits and spot check process.

16.2 Mrs Fiona Sandford enquired about the transfer of high consequence infectious diseases cases to the NHS Lothian Infectious Diseases ward and their unwillingness to accept transfers. Mr Whiting commented that the view of Public Health and Infection Control was that appropriate transfers were to take place and be accepted by NHS Lothian.

16.3 Dr Sohail Bhatti commented that the transfer of infectious disease patients illustrated the complexity of the issue and that NHS Lothian had to accept the patients as there were no facilities locally and he suggested that a regional pathway should be developed.

16.4 Mr James Ayling enquired about the Surgical Site Infection (SSI) rates for hips and sought clarification on if NHS Borders was an outlier. Mr Whiting confirmed that whilst SSI rates were above the average rates, statistical analysis confirmed that NHS Borders was not a statistical outlier.

16.5 Dr Bhatti commented that he would request that the Regional Health Protection service provide intelligence on SSI rates in the community.

The **BOARD** noted the report.

The **BOARD** confirmed it had received Limited Assurance from the report based on reflection on the transfer of high consequence infectious diseases cases which required resolution.

17. NHS Borders Performance Scorecard

17.1 Mrs June Smyth provided an overview of the content of the report and highlighted several elements including key standards against the 24/25 delivery plan and the narrative around cancer performance.

17.2 Mr Peter Moore congratulated the staff involved in the award to NHS Borders of the Golden Hip Award. He noted that formal presentation of the award would be made on 21 February 2025.

17.3 The Chair formally recorded the congratulations of the Board to the Team involved on achieving the award.

17.4 Mrs Lucy O'Leary sought clarification on the term "pooling patients" and any consequential impact. Mrs Smyth advised that she would follow up the matter outwith the meeting.

17.5 Mrs Fiona Sandford sought information on the theatre scheduling solution "Infix". Mr Moore commented that it had been confirmed to the Scottish Government that NHS Borders were interested in the implementation of "Infix" and work was taking place on the detail of an implementation plan.

The **BOARD** agreed that a report on "pooling patients" be submitted to the Resources & Performance Committee.

The **BOARD** noted performance as at the end of December 2024.

The **BOARD** confirmed it had received Limited Assurance from the report.

18. Consultant Appointments

The **BOARD** noted the report.

The **BOARD** confirmed it had received Significant Assurance from the report.

19. Any Other Business

19.1 **Staff Governance:** Mrs Lynne Livesey raised a numbers of concerns in regard to the Staff Governance and the amount of air time that it is given at the Board. She wished to see it given the same level of scrutiny as finance and clinical governance issues and suggested a report be submitted to each meeting. She further highlighted that regardless of pressures on staff, lack of resource or sickness absence the Staff Governance Committee had met without the minutes of the last 2 meetings being available and that was totally unacceptable.

19.2 In regard to Whistleblowing she advised that she had a number of concerns in regard to the process, how investigations were commissioned, timeliness of information and decisions and wished clarification on the Executive Lead.

19.3 Mr Peter Moore agreed that it was important to receive challenge and clearly the right processes were required to be in place and to be resourced appropriately so that it worked effectively. He emphasised that staff were the greatest asset of the

organisation and should be supported. He recognised that there were issues in terms of resource and it had to be realistically resourced moving forward.

19.4 He advised that he would be happy to meet with Mrs Livesey outwith the meeting to go through the 2 specific issues raised as how to support staff was fundamentally where those matters came down to. He suggested there was an opportunity to structure them differently moving forward and link to the strategic work being taken forward. He was keen that processes were resourced correctly and given time to work effectively.

19.5 The Chair reflected that workforce issues should be afforded the same exposure as financial matters and suggested a regular report be received.

19.6 Mrs June Smyth commented that conversations were taking place in regard to an integrated reporting approach and that would include areas of interest to the Board and that would include workforce. She suggested it would be done in a manageable way in terms of resourcing and she would be happy to include the Chair of the Staff Governance Committee in those conversations.

19.7 Mrs Lucy O'Leary reminded the Board of the integrated workforce strategy.

19.8 Dr Sohail Bhatti commented that he welcomed the exposure of workforce issues to the Board to gain more traction and understanding of the operational challenges in the organisation.

19.9 Mr Andy Carter commented that he welcomed all the observations and the helpful constructive criticism provided and he was keen to tighten up on areas of staff governance and support the strengthening of the whistleblowing model.

19.10 Mrs Livesey commented that she welcomed the comments made and that there was one area of whistleblowing that had to remain with Mr Carter and that was the training of whistleblowing by line managers and data on appraisals and when they were not done and there was a lack of follow through on actions being raised it was a high risk area for the Board.

19.11 She further said she did not think the NHS framework said that staff got the same air time at Board level and she said it needed serious and immediate attention and she reiterated on the lack of minutes being a technicality, if minutes were not produced in time it was not an excuse, it was so discussion could be recorded and actions produced and they were not circulated and therefore were not being actioned.

19.12 Mrs Sarah Horan advised that she was the Executive Lead for the Health and Care (Staffing) (Scotland) Act 2019 implementation and that quarterly reports were produced and the Board would receive an annual report each April. The quarterly reports would be submitted to the Staff Governance Committee. She asked that a Non Executive join the local Heath and Care Staffing Board. Mrs Livesey offered to be that Non Executive member.

The **BOARD** noted the update.

The **BOARD** agreed that Mrs Lynne Livesey be a Non Executive Member on the Health & Care Staffing Board.

20. Date and Time of next meeting

20.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 3 April 2025 at 10.00am in the Council Chamber at Scottish Borders Council and via MS Teams (hybrid).

Borders NHS Board Action Point Tracker

Meeting held on 3 October 2024

Agenda Item: Quality & Clinical Governance Report

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-4	11	The **BOARD** agreed to receive further information in regard to the interlinks of complaints and SAERs.	**Laura Jones**	**In Progress:** Explanation paper to be brought to the Clinical Governance Committee in January 2025 ahead of the February 2025 Board meeting. **Complete: Update 06.02.25:** Mrs Harriet Campbell commented that an explanation paper was presented to the January Clinical Governance Committee meeting and matters would be picked up under the Quality and Clinical Governance Report item on the agenda. The Board agreed to close the action on the action tracker.

Agenda Item: NHS Borders Performance Scorecard

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-5	16	The **BOARD** noted that the ACF Chair would progress linking the ACF through the Clinical Governance Committee in terms of activities across independent practitioners.	**Kevin Buchan**	**In Progress: Update 05.12.24:** Mrs Laura Jones advised that Dr Kevin Buchan, Mrs Sandford and herself had met and discussed linkages between the ACF and Clinical Governance Committee. Some issues required a more operational reporting line and it was agreed to keep the item open on the Action tracker whilst further discussions took place.

				Update 06.02.25: The Chair advised that the Chair of the ACF had resigned and an election would be held for a replacement. Mrs Fiona Sandford commented that it was important for the Board to receive a strong voice from independent practitioners particularly GPs. **Update 26.03.25:** The Chair of the GP Sub election was required to take place before the election of the Chair of the ACF. The election for the Chair of the GP Sub was scheduled for 31.03.25.

Meeting held on 5 December 2024

Agenda Item: British Sign Language (BSL) Plan 2024 to 2030

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2025-1	15	The **BOARD** noted that it had previously requested to receive a regular report from the Staff Governance Committee on staffing.	**Andy Carter / Cllr David Parker**	**Update 06.02.25:** It was noted a discussion would take place under any other business in regard to the Staff Governance Committee. The action would remain live on the action tracker.

Agenda Item: Primary Care Improvement Plan Annual Report

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2025-2	17	The **BOARD** agreed that the Non Executives Group should receive a separate session on the PCIP Annual Report.	**Chris Myers**	**Update 06.02.25:** Mr Chris Myers suggested a joint session be held with members of Borders NHS Board and members of the Integration Joint Board on 19 March 2025. **Complete:** Joint session held on 19.03.25.

Meeting held on 6 February 2025

Agenda Item: NHS Borders Performance Scorecard

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2025-3	17	The **BOARD** agreed that a report on "pooling patients" be submitted to the Resources & Performance Committee.	**June Smyth**	**In Progress:** Report scheduled for 8 May R&PC meeting.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Chief Executive's Report**
Responsible Executive/Non-Executive:	**Peter Moore, Chief Executive**
Report Author:	**Peter Moore, Chief Executive**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

In this update I want to reflect on my first six months in post, recognise the pressures we are currently facing but also look forward to what we have in front of us for 2025/26.

2.2 Background

Taking a step back and reflecting back on my first six months in post, four key things really standout.

- Firstly, I have to recognise the warm welcome I received not only across NHS Borders, but wider across our partners locally, regionally and then nationally.

- Secondly, is the quality of care the we provide across the organisation which is demonstrated on a weekly basis with the feedback we get from our patients. This is also demonstrated through the success individual staff and teams have made over the last few months – this recognition is brilliant to see.

- Thirdly, we are a small health board, and that means our resources are tight, which means our people have to be really flexible to cope with the challenges we face. This is evident in how flexible people are here, but also in how we work together – witnessing that team work first hand in various difficult situations is humbling and also a great foundation for our future. We have seen this in the success we have achieved this year in either managing through situations, or issues such as improving our financial position.

- Finally, the potential we have as a health board is huge. I do appreciate the scale of our challenges, but I also see clearly where some of our opportunities can really make us a better organisation, better to work for and who better meet the needs of our patients.

2.3 Assessment

Looking at where we are today is difficult. We know we have waits for care which are too long, we have significant challenges to our infrastructure, and we can't just spend our way out of this locally or nationally. We must approach providing treatment and care for our long wait patients methodically through prioritising both the longest waits, and also those with the greatest clinical need.

We have been successful in our savings over the last 12 months, and getting closer to a more sustainable position. While we do this, we must also be clear that healthcare demand will continue to increase each year through both increasing age of our population, and the impact of the greater burden disease has on our services. Making services cost less won't mitigate this demand, so we will need to develop new services that fundamentally support our patients to keep themselves well and when they need additional support this is provided in a planned way through community services. What our new strategy will illustrate are some ways that we do this, but by putting our patients at the centre of what we do. The best organisations are driven by a really clear 'why' and coming back to the reflections I made above, the 'why' for NHS Borders isn't to save money, it is to make sure we develop the best services which provide the best care for our patients in the communities we serve.

I am really excited to be starting this financial year with our new strategy which is going to be shared at an extraordinary board meeting later this month. I won't talk too much about the strategy, but it is based on the feedback we got from 1400 staff and members of our community, each answering five key questions. The focus for this year is going to be developing our Clinical Strategy alongside resetting our governance structure. Engaging our clinicians and professional leads in solving some of the most challenging issues we have is fundamental, our front line staff are those who know our patients and their communities best so putting them in the driving seat makes sense. Once we have gathered the thoughts of our clinical leaders we can then use this to prioritise the other support functions i.e. finance, digital, workforce etc. Next we will need to change how our organisation works to be able to deliver these ambitions in an open and honest way. Resetting our governance structure is

complex, but also really important. Delegating decision making and bringing in wider perspectives from the shop floor is really important. We also need to embrace a new way of reporting that is more open and transparent so for each year of the strategy we are going to be setting some really clear measurable and deliverable goals. These will be in the form of an Annual Horizon report, that our organisation will use to track progress and the impact this has.

What you will see through this year is a change in our reporting, how we approach issues and also how we really impact positively on those in our communities who need our support.

2.3.1 Quality/ Patient Care

None arising from this report.

2.3.2 Workforce

None arising from this report.

2.3.3 Financial

None arising from this report.

2.3.4 Risk Assessment/Management

None arising from this report.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Climate Change

None arising from this report.

2.3.7 Other impacts

None arising from this report.

2.3.8 Communication, involvement, engagement and consultation

Not required.

2.3.9 Route to the Meeting

This report has been produced specifically for the Board.

2.4 Recommendation

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

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

The following appendices are included with this report:

None.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Health Board Collaboration and Leadership, NHS Scotland Executive Group**
Responsible Executive/Non-Executive:	**Peter Moore, Chief Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Emerging issue
- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

2.1.1 This paper sets the context for renewal and reform following the First Minister's statement on 27 January 2025.

2.1.2 The content of this paper has been agreed nationally and Chief Executives have been asked to each take the report to their own Board at their next scheduled meeting.

2.1.3 The paper aims to brief NHS Boards on the new governance arrangements with the establishment of the NHS Scotland Executive Group and wider efforts to support a more collaborative ethos in NHS Scotland.

2.1.4 It also describes the need for all NHS Boards to ensure a systematic approach to balancing local delivery with the need to contribute to meet the needs of larger populations – beyond their geographical boundaries – in the delivery of planned care.

2.1.5 Board members are asked to acknowledge and endorse the duality of their role for the population/Bard they serve, as well as their contribution to population planning that will cross traditional Board boundaries. The Board is asked to approve local implementation of this approach and note the anticipated increased pace of change and requirement for regional and national collaboration in coming weeks and months.

2.2 Background

2.2.1 The First Minister's statement on Improving Public Services and NHS Renewal on 27 January 2025, emphasised the need for NHS Boards to work collaboratively to achieve the principles and aims that he set out: improved access to services; shifting the balance of care to the community; focus on innovation to improve access to; and delivery of care.

2.2.2 The First Minister's statement reflected the shift sought in DL(2024)31: A renewed approach to population-based planning across NHS Scotland, which was published on 28 November 2024. The DL emphasises the need for service planning to align with the population size and be collaborative. It highlights a significant shift in planning, organising, delivering, and potentially funding services to meet Scotland's changing needs and ensure high-quality, sustainable services. NHS Boards will be required to collaborate across NHS Board boundaries – and with Scottish Government – to implement these principles, particularly through the annual delivery plan process.

2.3 Assessment

2.3.1 NHS Board Chairs and Chief Executives received a letter on 7 February 2025 from the Director General Health and Social Care and Chief Executive of NHS Scotland (DGNHS) setting out expectations about collaboration. This letter reaffirmed the principles set out in DL(2024)31 with an expectation for increased collaboration between NHS Boards for to help improve the health and wellbeing of the citizens and communities of Scotland and is aligned to the principles of co-operation and assistance as set out in section 12 (J) of the 1978 NHS Scotland Act.

2.3.2 This letter also aligns with the key priority deliverables set out in the First Minister's speech on 27 January 2025 which aims to improve access, reform and equity for the people of Scotland.

Governance Arrangements

2.3.3 Over the past year, steps have been taken to revise national governance arrangements. This is intended enhance collaborative working in recognition that the challenges facing the NHS and social care require a system-level leadership and corporate working across NHS Board boundaries.

2.3.4 In October 2024, the NHS Scotland Executive Group was established. It is co-chaired by the Director General Health and Social Care and Chief Executive of NHS Scotland and the Chair of Board Chief Executives Group. This newly formed group provides collective leadership in addressing key issues which require a national perspective. NHS Chairs received a briefing on the role of the Group on 5 November 2024.

2.3.5 NHS Boards are working to advance practical examples of building a more cohesive approach to the design and delivery of services on behalf of NHS Scotland. NHS Board Chief Executives undertook a successful two-day session on group development and digital innovation in September 2024 at the National Robotarium in Edinburgh. In relation to adoption of new digital developments and products it was agreed that the default position should be national development approach and local adoption. It was also recognised that this principle may well apply in a range of other planning matters.

Renewal and Reform

2.3.6 Since the end of 2024, a small cohort of Board Chief Executives, on behalf of the wider NHS Board Chief Executives Group, have contributed to a weekly reform coordination group. This group also includes senior Scottish Government officials and was set-up to create early dialogue on the phasing of reform and renewal plans due to be published this year. NHS Board Chief Executives have welcomed this approach as it has enabled NHS representatives to meaningfully contribute to and influence the early approach on reform and renewal.

2.3.7 Representatives of the reform coordination group led on delivery of a joint Chief Executives/Executive Leads and Scottish Government session on NHS Renewal, held at COSLA on 18 February. This session explored the current position of the 3 'products' that are due to be published in the first half of 2025:

- Operational Improvement Plan (by the end March)
- Population Health Framework (Spring)
- Health and Social Care Service Reform Framework (pre summer Scottish Parliament recess)

2.3.8 These policy documents will provide the platform for the delivery of the First Minister's commitments. There is significant opportunity for NHS Board Chairs, Chief Executives and teams to contribute to this work, as well as partners, patients and communities themselves. It is important that NHS Boards contribute to the scrutiny of any proposals to ensure that the plans are deliverable.

2.3.9 In parallel to reform, there is renewed focus on wider public sector reform and efficiency and productivity with an onus on Chief Executives and NHS Boards to ensure that all opportunities for service efficiency and improvement are explored and delivered, whilst simultaneously progressing longer term reform. A paper will be presented to the NHS Scotland Executive Group on 6 March on Business Services which will demonstrate opportunities available to NHS Boards to deliver transformation of business services and supporting systems.

Improvements in Planned Care

2.3.10 NHS Board Chief Executive representatives updated colleagues on weekly meetings they had contributed to which were convened and chaired by the First Minister, including the Cabinet Secretary for Health and Social Care and Scottish Government officials. This has resulted in the development of a National Planned Care Framework, which sets out a number of principles for achieving the necessary improvements in planned care.

2.3.11 The Framework seeks to create a balanced planned care system, ensuring all patients in Scotland have equal and timely access to care. It aims to maintain or improve care standards while balancing short-term and long-term actions on waiting lists. This draft framework was discussed and approved by the NHS Board Chief Executives Group on 19 February. It will now be subject to engagement with NHS Boards.

2.3.12 The National Planned Care Framework exemplifies new working methods, adhering to the principles of cooperation and assistance outlined in section 12(J) of the 1978 NHS Scotland Act. As we advance in planning, organising, delivering, and potentially funding services to meet Scotland's evolving needs and lay the groundwork for service transformation, the Director General Health and Social Care and Chief Executive of NHS Scotland is committed to reviewing and modifying the performance governance of individual Boards to reflect this new approach, emphasising collective accountability. This will be important as there will likely be a requirement to adopt a collaborative approach to delivery across other key areas of healthcare policy.

2.4.1 Quality/ Patient Care

None arising from this report.

2.4.2 Workforce

None arising from this report.

2.4.3 Financial

None arising from this report.

2.4.4 Risk Assessment/Management

A more systematic approach to population based planning and collaboration across Boards is intended to support mitigation of risk across NHS Scotland particularly within the context of planned care.

2.4.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

2.4.6 Climate Change

None arising from this report.

2.4.7 Other impacts

None arising from this report.

2.4.8 Communication, involvement, engagement and consultation

This paper has been agreed by NHS Scotland Board Chief Executives at their meeting on 5 March 2025 and each Board is receiving the same paper at meetings in March and April for endorsement.

2.4.9 Route to the Meeting

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

- Board Chief Executives, Executive Leads and Scottish Government officials met at COSLA on 18 February 2025 to share information and perspectives on NHS renewal.
- NHS Scotland Executive Group, 5 March 2025.

2.5 Recommendation

NHS Borders Board is asked to **note**:

- the commitment set out by the First Minister to progress the renewal and reform of the NHS in Scotland, and associated requirement for the Board to seek assurance on delivery of these commitments;
- the evolution of the new governance arrangements which are intended to enable and foster stronger collective accountability whilst underpinning the strength of local accountability mechanisms.

NHS Borders Board is asked to **acknowledge and endorse**:

- the duality of their role for the population/Board they serve as well as their contribution to population planning that will cross traditional Board boundaries and approves local implementation of this approach, consistent with DL(2024)31 and 12 (J) of the 1978 NHS Scotland Act;
- the anticipated increased pace of change and requirement for regional and national collaboration in coming weeks and months as there is requirement to deliver the principles set out by the First Minister in his speech on 27 January, to deliver efficiencies and savings and to put into action the commitments set out in the three reform documents.

NHS Borders Board to **note** that in response to these changes, it is recognised that there is requirement to refresh the traditional approach to Board performance framework and indeed Executive personal objectives, which was referenced in Caroline Lamb's letter of 7 February.

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, Letter from Caroline Lamb, Chief Executive of NHS Scotland and Director General for Health & Social Care dated 07.02.25.
- Appendix No 2, DL(2024)31.
- Appendix No 3, Section 12 (J) 1978 NHS Scotland Act.

Director-General Health & Social Care and
Chief Executive NHS Scotland
Caroline Lamb

E: dghsc@gov.scot

Scottish Government
Riaghaltas na h-Alba

All NHS Chairs and NHS Chief Executives

7 February 2025

Dear Colleagues

Following the First Minister's recent keynote speech on improving public services, I am writing to seek your support in taking forward the programme of reform and renewal for our NHS. The NHS Chairs meetings and the advent of the NHS Scotland Executive Group has meant a fundamental shift in the way we come together and lead the NHS, but we need to increase the pace at which we are implementing the range of improvements across our system, in order to maximise the effectiveness and efficiency of services.

In taking forward the range of system reform and improvement work, it is important that we fully utilise the opportunities provided by working across boundaries – giving life to the statutory duties placed upon all NHS Boards to work collaboratively in delivering healthcare services. This duty is set out in Section 12J of the National Health Service (Scotland) Act 1978 and provides the foundation for ensuring equitable and effective healthcare delivery across Scotland.

As system leaders, you are required to ensure that your Boards actively engage in collaborative arrangements with other Health Boards. This includes sharing resources, expertise and services, where appropriate, to optimise patient outcomes and improve efficiency across the system. Such co-operation is critical to achieving the best possible care for our population, especially given the complex challenges we face in addressing health inequalities and meeting the demands on services.

Over the last year we have strengthened our approach to collaboration and co-operation with you, beginning with the publication of the Model Framework Document for NHS Boards in April 2024. This document outlines how we collaborate and co-operate and provides a structured approach for Boards, detailing our respective roles, responsibilities, and the nature of how Boards interact with the Scottish Government. It aimed to provide greater clarity on governance and accountability and sets out our commitment to fostering effective partnerships to deliver high-quality healthcare services across Scotland.

Our commitment to working together has been further strengthened with the establishment of the NHS Scotland Executive Group, which first met in October 2024. Its primary aim is to support the effective governance, planning and delivery of healthcare services across Scotland. The NHS Scotland Executive Group plays a central role in supporting national and

regional planning initiatives, such as those outlined in the NHS Scotland Planning Framework.

The recent publication of the NHS Scotland Planning Director's Letter, in November 2024, provides additional guidance on population-based planning, once again highlighting the need for strengthened national and regional coordination. The DL emphasised the establishment of a Single Planning Framework to ensure coherence and alignment in service delivery, infrastructure investment, and workforce planning at national level. The NHS Scotland Planning and Delivery Board (NHSSPDB) will oversee and govern these efforts, ensuring that resources are deployed efficiently and equitably across all Health Boards.

At the regional level, the letter outlines the importance of collaboration between neighbouring Health Boards to develop strategies that address the specific needs of local populations. Regional planning groups are expected to drive innovation and adaptability, responding to the unique health dynamics within their areas whilst aligning with the broader NHS Scotland priorities. These planning efforts are integral to achieving the vision set out in the 2016 National Clinical Strategy and the Public Bodies (Joint Working) (Scotland) Act, which prioritise integration and partnership working across sectors.

I believe we have all of the foundations now in place to allow you to fulfil your roles, as NHS leaders, but also in how we come together as an NHS Scotland to meet the needs of patients and the expectations of our communities.

Moving forward, I intend to work with employers to enhance the Executive Management Appraisal System so that we can properly assess and record the impact of working across board and wider system boundaries. This will be incorporated into the guidance for the 2024/25 performance review and 2025/26 objective setting process, which the Chief People Officer will issue in late February / early March. Similarly, the appraisals of NHS Chairs will encompass how they are facilitating and supporting the level of cross boundary working that we all see as essential.

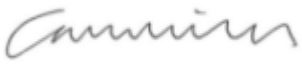
For now, I encourage you all to review your current arrangements for cross-boundary collaboration and identify any areas requiring improvement. Please also ensure that staff within your Boards are familiar with the statutory requirements of the Model Framework.

In the meantime, should you require clarification or support, please do not hesitate to contact my office.

Thank you for your continued leadership and dedication to delivering high-quality, patient-centred care for the people of Scotland.

Yours sincerely,

Caroline Lamb



Director General Health and Social Care and Chief Executive NHS Scotland

The Scottish Government
Directorate of the Chief Operating Officer, NHS Scotland

Scottish Government
Riaghaltas na h-Alba
gov.scot

E: john.burns@gov.scot

Dear Colleagues

A RENEWED APPROACH TO POPULATION BASED PLANNING ACROSS NHS SCOTLAND

Purpose of this DL

1. The purpose of this Directors Letter is to act as an enabler to reform and sets out the actions for NHS Boards associated with the renewed approach to population planning across NHS Scotland, as set out in the National Clinical Strategy (NCS).

Background

2. As part of the wider health and social care reform agenda, work has been underway to develop a renewed approach to planning of services in NHS Scotland, with an increased focus on the actions to move to the population level planning reflected in the NCS.

3. As established in the NCS, our planning across NHS Scotland needs to ensure that planning for services is undertaken at a level which is best aligned to the size of population who make use of those services, and that this is undertaken in a collaborative and coherent way.

4. This will be a significant change to the way we plan, organise, deliver and potentially fund services to enable us meet changing needs of Scotland and build the foundation for the transformation of our services.

5. These changes are underpinned by the statutory duty of NHS Boards to co-operate for the benefit of the people of Scotland, as in the *National Health Service Reform (Scotland) Act 2004,* which requires effective inter-Board co-operation in the planning and delivery of services for population groups which span more than one NHS Board area. The actions set out in this letter

DL (2024) 31

28 November 2024

Addressees

For action
NHS Scotland Chairs
NHS Scotland Chief Executives
NHS Scotland Directors of Planning

For information
NHS Scotland Directors of Finance
NHS Scotland Directors of HR

Enquiries to:
Scottish Government
Directorate for the Chief Operating Officer, NHS Scotland

E-mail:
dcoohealthplanning@gov.scot

are a key element of how NHS Boards will fulfil that duty.

6. This letter does not change any responsibilities on NHS Boards regarding their planning responsibilities as set out in *Public Bodies (Joint Working) (Scotland) Act*.

7. In summary, this DL covers

   - arrangements for national, regional and cross-Board collaborative planning;
   - the role of the NHS Scotland Planning and Delivery Board and Strategic Planning Board in providing leadership and oversight of population level planning;
   - assurance on the alignment of this move to planning on a population level with work underway on Whole System Infrastructure Planning.
   - a commitment that the Scottish Government will review and update how it commissions activity from the NHS Boards (particularly National Boards), to develop greater strategic oversight and coherency; and
   - reassurance that existing 'Place Based' integrated health and social care planning processes and governance remain in place, and that obligations set out in the *Public Bodies (Joint Working) (Scotland) Act (2014)* remain unaffected.

8. In codifying processes which have been established over the past 12-18 months, this letter naturally supersedes the following Health Department Letters (HDLs):

   - '***NHS Scotland: Guidance on Regional Planning for Health Care Services'*** *HDL (2002)10; and*
   - ***'Regional Planning'*** *HDL (2004) 46*

Action

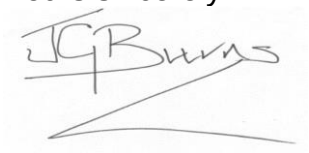
9. The actions within this DL are summarised below:.

   - Boards to note the revised groupings for Regional working and for each Region to nominate a BCE as Regional Lead and the cohort of National Boards to nominate a BCE Lead, for a minimum two year period.

- Leadership teams are asked to demonstrate a strong commitment to collaborative working and instil collaborative cultures and a common purpose within their organisations, from the frontline to the board.
- To note creation of National Planning Executive Group
- To note that work is continuing on stronger alignment and refresh of Clinical Networks, which will result in a future DL.
- To note the annual publication of the list of Indicative Planning Populations.
- Once finalised, each Board will have a list of the services they have agreed with Scottish Government to deliver, which will ensure clarity on Scottish Government expectations of them. This will seek to include services that Boards are obliged to deliver, under enduring responsibilities, for others.
- As we update the Indicative Planning Population List in future years, Regions and Boards will be asked to confirm any changes to their planning arrangements.
- To note the development and application of a new Prioritisation Framework
- To note the resetting of work on development of a 20-30 year Whole-System Infrastructure Plan, which will be taken forward, in the first instance, through the National Infrastructure Board.
- To note the proposed new approach to commissioning and assessing proposals to deliver services.

10. In setting out these changes and moving to a population approach to planning of services, we recognise this will require a level of change culturally in working collaboratively. We will work with Board Chief Executives, and other system leaders, to consider how we best engage teams in working in this new way.

Yours sincerely



John Burns
Chief Operating Officer - NHS Scotland
NHS Scotland Chief Operating Officer

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

A renewed approach to population based planning across NHS Scotland

Contents

1. Introduction and Background

A significant change to the way we plan, organise, deliver and fund services is required to meet the challenges and changing needs of Scotland's population and, as critically, build the foundation for the transformation of our services.

The changes to planning set out in this document focus primarily on those clinical services that are the direct responsibility of Health Boards, whilst recognising that such planning takes place within the broader context of whole system health and social care planning and public sector reform. In doing so therefore we need to ensure that the whole system enables effective integrated planning so that changes in one part of the system are not at detriment to capacity in another.

Furthermore, the work to develop a long-term primary care reform plan known as a "Route Map", supported by the national Primary and Community Health Steering Group, will set out key aspects of both how the primary care system operates currently and how it will operate in the context of wider reforms, including what future planning requirements look like and the role of Health Boards as part of this.

This DL is importantly set in the context of the renewed focus on prevention, as indicated in the parliamentary debate on health on 4 June 2024. The development of the population health framework will set out to enable Boards review, describe, prioritise and further develop their contributions to population health, and contribute to the increasingly integrated approaches to the planning and delivery of care.

In codifying processes which have been established over the past 12-18 months, this letter naturally supersedes the following Health Department Letters (HDLs):

- '***NHS Scotland: Guidance on Regional Planning for Health Care Services'*** *HDL (2002)10; and*
- *'**Regional Planning'** HDL (2004) 46*

This guidance is also underpinned by the statutory duty of NHS Boards to co-operate for the benefit of the people of Scotland contained in the *National Health Service Reform (Scotland) Act 2004.* This requires effective inter-Board co-operation in the planning and delivery of services for population groups which span more than one NHS Board area, and the guidance set out in this document is a key element of how NHS Boards will fulfil that duty.

This DL does not change any responsibilities on NHS Boards or Integration Authorities regarding their planning responsibilities as set out in Public Bodies (Joint Working) (Scotland) Act and expectations on working across boundaries. NHS planning taking a more collaborative approach to national, regional and cross border planning, and coordination with local service planning all on a population basis, complements the Public Bodies (Joint Working) (Scotland) Act outcomes, which will continue to apply across health and social care, and will help to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services.

2. Context

This DL sets out the approach to planning across populations and aligns with the vision for Health and Social Care set out by the Cabinet Secretary in June and the

principles set out in the 2016 National Clinical Strategy, which will be enabled through the development of the National Clinical Framework..

The National Clinical Strategy set out four strategic design principles, which form the frame for our planning framework for services locally, regionally and nationally:

- Delivering more services closer to home in the community: with more acute services delivered in community settings.
- Equally, more specialist services delivered in more concentrated centres.
- Sustainable services across a population
- Digital and innovation as an integral part of delivery

The National Clinical Strategy also established the principle that appropriate clinically led planning for services is undertaken at a level which is best aligned to the size of population who make use of those services, and that this is undertaken in a collaborative and coherent way, with appropriate national leadership.

In support of this, in October 2023 the National and Regional Planning and Delivery Short Life Working Group produced high level recommendations, providing the initial direction for a more integrated, collaborative and coherent approach to the planning and delivery of health and care services nationally and regionally for the population of Scotland:

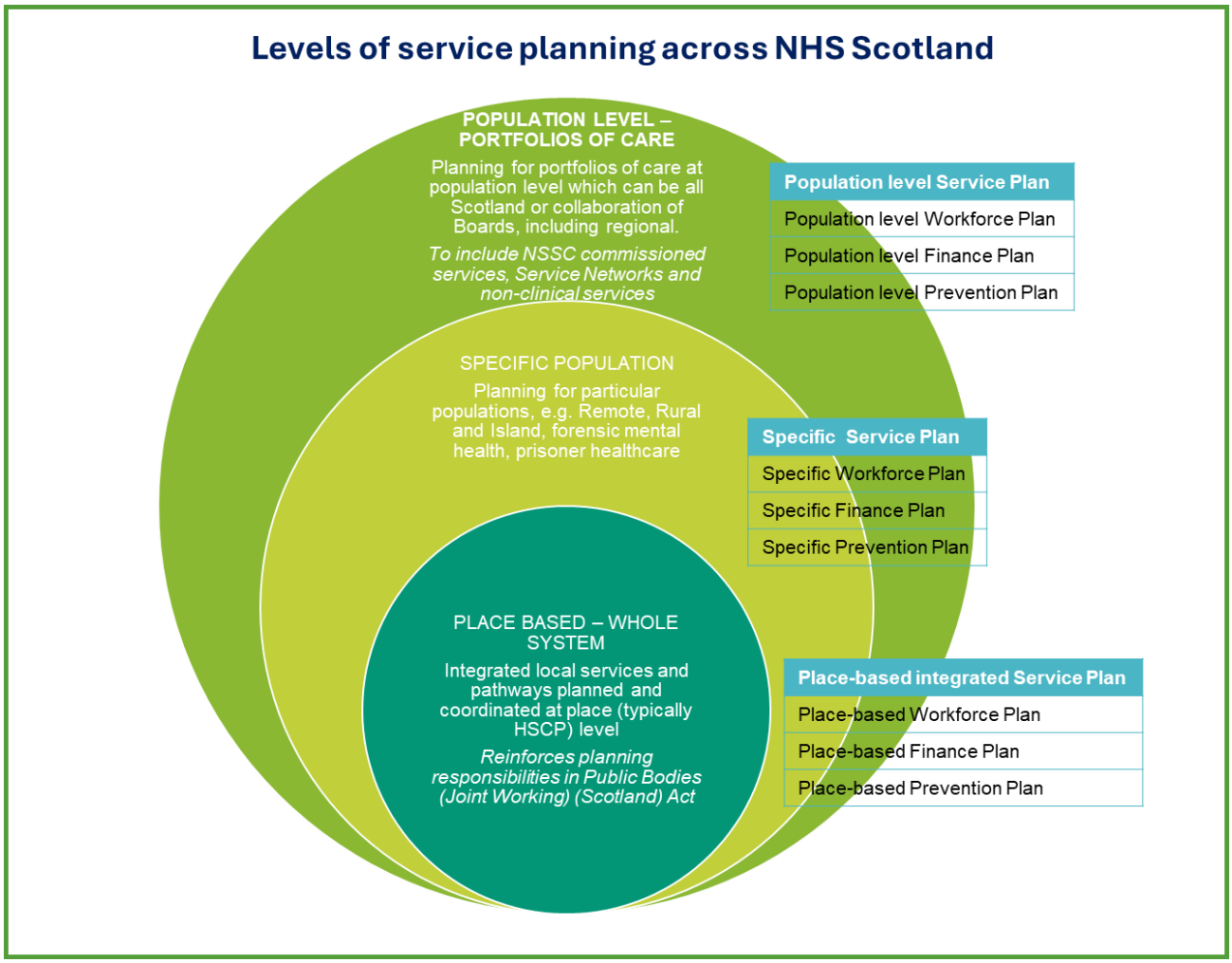
- Development of a Single Planning Framework
- Strengthening of coherence across National and Regional Planning
- Stronger understanding of the role of Networks and associated Groups

These recommendations have set the strategic direction of planning and delivery, as set out in this guidance, as a key enabler for the reform vision and programme introduced by the Cabinet Secretary for Health and Social Care in June 2024. A programme of reform and improvement is already underway in Primary Care, working closely with health and social care colleagues across the system to ensure an integrated approach overall.

3. Planning for services across NHS Scotland

The renewed approach for planning for NHS Scotland services reflects three levels of planning, as set out in Diagram 1 – Population level; Specific Population level; Place Based level noting also that planning incorporates clinical and non-clinical service planning. As this evolves, each level will also have aligned service, workforce and financial plans and critically a Prevention Plan that sets out actions to improve planning for prevention within each level.

Diagram 1: Levels of service planning



The Single Planning Framework will support sustainable service planning with the development of clear target operating models ensuring greater coherence, consistency and more effective use of resources. Models will demonstrate where accountabilities sit for different elements of the approach, how population based planning should inform local planning, and where issues are identified clear governance routes displaying how these can be escalated appropriately.

This Framework will also evolve to reflect the role of our National Boards in supporting the move to population level planning and to ensure coherence of planning and commissioning across our system.

4. ‘Place Based’ Integrated Health and Social Care Planning

The changes to planning set out in this document focus primarily on those services that are the direct responsibility of Health Boards, whilst recognising that such planning takes place within the broader context of whole system health and social care planning and public sector reform. It is also expected that, in the instances where services are delegated to local Integrated Joint Boards (IJBs), the planning of these services is undertaken collaboratively.

NHS planning, whether at national, regional or Board level must consider demand and capacity requirements across health and social care and the interdependencies within our systems. Planning will be undertaken in a complementary way and, where appropriate, will be clearly aligned to Integration Authorities' Strategic Plans and priorities, referencing sustainability and workforce plans.

This document does not change any responsibilities on NHS Boards or Integration Authorities regarding their planning responsibilities as set out in the Public Bodies (Joint Working) (Scotland) Act. NHS planning taking a more collaborative approach to national, regional and cross border planning, and coordination with local service planning all on a population basis, complements the Public Bodies (Joint Working (Scotland) Act outcomes, which will continue to apply across health and social care, and will help to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services.

5. Sustainable service planning

In early 2024, an assessment of services with sustainability and resilience issues within individual NHS Boards was undertaken. This identified a concerning range of services as being unsustainable, demonstrating the need to urgently consider individual board approaches to planning and delivery, and instead use the opportunity to develop and introduce a new way of planning by collaboratively developing the national single planning framework.

Phase 1 consisting of Oncology, Vascular, Diagnostics, and Remote, Rural and Islands, are underway, with Task and Finish Groups defining the problem statement and understanding existing models for their specialty. Work to develop Sustainable Operating Models, for the short term, and Target Operating Models (TOMs), for medium to long term planning, will incorporate a population planning approach. Membership of these Task and Finish Groups include appropriate clinical and professional representation from Boards and report into the NHS Scotland Planning and Delivery Board.

As part of this approach in planning services, we are working collaboratively with HIS-Community Engagement to consider how we engage communities on population level service change, with reference to the recently updated Planning with People Guidance[1], which sets out the engagement responsibilities for community engagement on service changes.

The next phase of sustainability reviews is under development including objective assessment criteria and will be progressed under the remit of the NHS Scotland Planning and Delivery Board. This will include the levels at which we plan for our non-clinical services, on the most appropriate population level.

As the approach to sustainable services evolves, the process will be refined to demonstrate that there is an effective process to recognise and respond to services that are at risk and, through robust articulation of risks, inform future phases of service reviews.

[1] Health and social care - Planning with People: community engagement and participation guidance - updated 2024 - gov.scot (www.gov.scot)

To support this, leadership teams, locally, regionally and nationally, are asked to demonstrate a strong commitment to collaborative working and instil collaborative cultures and a common purpose within their organisations, from the frontline to the board that recognises the priority of equity of access and outcomes for all across Scotland.

6. Indicative list of planning populations

The previous HDL (2002) 10, introduced a list of 'Indicative Planning Populations for Specialist Services' which highlights services planned and delivered on a regional basis; national basis; and with the UK.

The National Clinical Framework fully supports a population based approach and going forward this list will be reviewed and owned by the Strategic Planning Board, which will update it annually.

It is intended that this Indicative Planning Population list will be used as a baseline and companion piece to the Framework Document for NHS Boards, published by Scottish Government's Health Sponsorship Team. The document details the agreement across government and arms-length bodies, detailing the purpose and role of Scottish Government, Boards and the role of Health Sponsorship.

Once finalised, each Board will have a list of the services they have agreed with Scottish Government to deliver, which will ensure clarity on Scottish Government expectations of them. This will seek to include services that Boards are obliged to deliver, under enduring responsibilities, for others.

The process enables a transparent governance approach for service provision, and will provide a formal route for Scottish Government and NHS Boards to decide on whether they will stop/start delivering specific services.

7. Ways of working

Governance and reporting

In recognition of the need to work differently and more collaboratively, a revised governance structure has been introduced to support the DG Health and Social Care and Chief Executive NHS Scotland.

The NHS Scotland Executive Group (NHSEG) is a key lever to deliver transformation at a national level. The group will make decisions and recommendations on what should be delivered at a national level across relevant Health Boards.

The Executive Group is supported by a sub structure, which includes the NHS Scotland Planning and Delivery Board and Strategic Planning Board, who have a role in providing leadership and oversight of population level planning.

Mechanism for collaborative planning

Regional and national planning arrangements are described within two HDLs from 2002 and 2004. However, the strategic context has changed significantly since then with the publication of the Quality Strategy, new strategic planning mechanisms for integrated local services and pathways through the 2014 Public Bodies (Joint Working) (Scotland) Act. Most recently, in June 2024, the Cabinet Secretary for Health and Social Care set out his vision for achieving sustainable quality in the

delivery of healthcare services across Scotland reiterating the principles of the National Clinical Strategy.

In addition, the National Health Service (Scotland) Act 1978, as amended by the Public Services Reform (Scotland) Act 2010 provides the enabling framework for Boards to work collaboratively together in the planning and provision of services, with a view to securing the health of the population of Scotland. Indeed Boards, and Regions, have already made great strides in improving collaboration in response to better sustaining services for patients and communities.

Regions will remain as a core mechanism to support working across Boards and, indeed, as we look to plan long term, based on population needs, regions could, depending on the population level required, take the lead on implementation. Although regions are a useful construct, they are not intended to constrain population level planning and we expect that collaborations will take place across Boards outwith the current regions for services to ensure we are best meeting the needs of patients.

In this context and to reflect current ways of collective working, we are taking the opportunity to redefine each region, as follows, reflecting that these host arrangements do not remove the need for individual Boards to link into multiple regions for specific services, as is currently the case.

- **North:** Grampian, Highland*, Orkney, Shetland and Tayside
- **West:** Ayrshire & Arran, Dumfries & Galloway*, Forth Valley*, Greater Glasgow & Clyde, Lanarkshire, Western Isles* and Golden Jubilee Hospital.
- **East:** Borders, Fife and Lothian

* It is recognised that NHS Dumfries & Galloway and NHS Forth Valley have patient pathways into the East of Scotland, Western Isles and Argyll and Bute into West of Scotland and it is expected that there is flexibility to enable them to engage across multiple regional areas.

As we update the Indicative Planning Population List (referenced in section 6), Regions and Boards will be asked to confirm any changes to their planning arrangements.

In addition, each Region will nominate a BCE to act as the Regional Lead on the NHS Scotland Planning and Delivery Board. It will be expected that this individual will hold this role for a minimum of two years. National Boards will also nominate a BCE Lead to represent the interests and ensure coherence into our National Boards.

It is vital that there is read across between all plans and therefore a collaborative planning approach is crucial. The way we will achieve this is by establishing a National Planning Executive Group with clear and coherent planning, at appropriate population level, through agreement of priorities and visibility of associated workplans.

This Group will provide advice and assurance to the NHS Scotland Executive through NHS Scotland Planning and Delivery Board and Strategic Planning Board. This new forum is not intended to get in the way of existing inter Board working and collaboration, rather it is to facilitate and encourage join-up across the system.

At the centre of this planning approach is coherence and therefore on an annual basis this Group will consider the **national planning priorities** alongside the priorities of regional planning groups to ensure read across between all plans.

National Specialist Services Committee (NSSC)

NSSC consider and advise/recommend NHS Boards and Scottish Government on the provision of nationally designated specialist services for Scotland. Ministers approved the role, remit and membership of the National Specialist Services Committee (NSSC) in 2012. Their objectives are to provide proactive planning of services that require national commissioning.

Recommendations from the Committee are made to NHS Board Chief Executives and through them to Scottish Government. The policy for national specialist services, including deciding upon which services should be nationally commissioned and any strategic change in provision, are set by Ministers.

As part of their role, NSSC oversee the financial arrangements for designated national specialist services through an annual funding round to set the budget for designated specialist services, including current National Managed Clinical Networks and Strategic Networks.

As we look to further evolve coherence, we will consider the impact on this changes in the DL on the role of NSSC, especially considering the introduction of the Strategic Planning Board. A future DL on realignment of Networks will be issued in 2025.

Funded National Specialist Services

NSS NSD currently manage the list of National Specialist Services commissioned by NSSC. Going forward SPB will work with NHS Boards and NSD to publish an updated list of National Specialist Service on an annual basis and will engage with NSSC as we recognise this needs to be a coherent part of the system. NSD will also sit on the proposed National Planning Executive Group in support of a single integrated approach to planning and prioritisation.

8. Prioritising resource

With support of colleagues across NHS Scotland work has been progressing in the development of a prioritisation tool as a single framework to allocate funding, and in parallel consider areas for disinvestment, to NHS Scotland priorities. In doing so, it will seek to enable:

- Evaluation of competing demands by considering value and the proven outcomes and linked to the Vision for Health and Social Care..
- Value-based decision making
- Transparency in decisions and demonstrates good organisational governance.
- A consistent way to prioritise or deprioritise across different situations/services.
- Priority setting that considers workforce resources.

The framework will be useful when faced with service developments (availability of new treatments or diagnostic procedures, changes in policy or redesign of health

care pathways) which demand reallocation of funding and seek to provide the most effective, fair, and sustainable use of finite resource. The approach will also critically consider the necessary de-prioritisation to manage resources within available funding. The method will follow a three-step process with the output of the process being a ranked list of priorities.

Workshops were held between May and July 2024 to agree scope, consider decision making criteria, undertake gap analysis and agree weightings. A report was taken to the NHS Scotland Planning and Delivery Board and the Executive Leaders Group in October for endorsement, with final approval anticipated in January, with a view to implementing this for 2026-27. The prioritisation will incorporate the NSSC commissioned services to ensure a combined set of prioritised funding decisions.

Following endorsement of the framework, there will be a requirement for all stakeholders to work in partnership to implement. The prioritisation exercise will be repeated at least annually.

9. Whole System Infrastructure Planning

On 12 February 2024, the Scottish Government issued the Director's Letter to all NHS Boards *NHS SCOTLAND: Whole System Infrastructure Planning – DL (2024) 02*. This outlined the requirements for all NHS Boards to prepare a whole-system infrastructure plan.

The first requirement related to submission, by January 2025, by Boards of a risk-based maintenance plan to support business & service continuity, aims to mitigate against some of the more serious inherent infrastructure risks. This will provide us with a baseline of infrastructure need for Scotland.

The second phase of work related to development of a 20-30 year Whole-System Infrastructure Plan, to support development of a national prioritised and deliverable investment programme. With the move to population planning of clinical services, the intention is that this work will now be set within the wider reform context and will be taken forward, in the first instance, through the National Infrastructure Board over the next few months. This presents the opportunity for service and infrastructure planning to be more co-joined so that deliverable service reform plans are formed which can prioritised alongside infrastructure needs and priorities. In doing so, consideration will also be given to development of a shared set of assumptions including trends in population migration across Scotland.

10. Scottish Government Commissioning of NHS Scotland Activity

As we look to take a population based approach to planning of services, we recognise the need to realign how we, in Scottish Government, commission, fund

and performance manage Boards to deliver outcomes. There is currently no overarching strategy for commissioning NHS services, technologies or medicines. Instead multiple independent commissioning routes have been adopted leading to a disjointed approach with little transparency or governance, creating the opportunity for duplication with unclear prioritisation and strategic direction, and potentially leading to mis-spent public monies.

As part of a renewed approach to planning for NHS Scotland, the Scottish Government will review and update its process for commissioning activity and move to a more coherent and consistent approach for assessing proposals for acute services. This will enable:

- clear internal direction for commissioning NHS Boards (enabling mutual understanding and agreement between SG and Boards)
- strategic overview: transparent assessment of future demands (horizon scanning) and therefore increased visibility and alignment of strategic activities/demands enabling reduced duplication across health directorate
- alignment with both SG and NHS Board financial planning
- informed decision making: prioritisation and value – directly linking to strategic objectives including the Vision for Health and Social Care prior to planning and approval stages
- consideration of a whole-systems approach and wider impacts of service planning
- clarity around the appropriate NHS Board(s) to commission for delivery of specific services
- strengthened ongoing monitoring procedures at a national level
- evidence-based decisions on decommissioning proposals

As with the Prioritisation Framework, it was agreed that the high level milestones within the National Services Directorate (NSD) annual commissioning process for designated national specialist services, would be used as a baseline and adapted to meet Scottish Government policy requirements for commissioning acute services.

Consideration will be given to incorporating existing objectives and processes to produce a clear and transparent approach which will enable an infrastructure for the new Prioritisation Framework to function. Implementation will be undertaken in phases and details on changes will be shared later this year.

11. Summary of Changes and Actions

The refreshed approach to planning across NHS Scotland aims to secure the best outcomes for patients and support our health services through planning and designing services collaboratively to ensure:

- Strong population based approach to planning of services, that consider needs of our people, integration with / read-across between workforce, financial and infrastructure planning and establish clear actions to improve prevention.
- Equity of outcomes and access across Scotland, with a clear line of sight to the overall vision for Health and Social Care and with delivery designed to meet local circumstances
- Efficiency and effectiveness, with service models designed to ensure high-quality, patient-centred and sustainable services;
- Clear governance, authority and lines of accountability across the planning landscape, resulting in equity of service provision as individual boards adopt consistent approaches.
- Strengthened understanding of and clarity on the remit, process and criteria for both national and regional planning.
- Improved collaboration of NHS Boards in national, regional and specialist planning.

It should be noted that work is underway through the NHS Scotland Planning and Delivery Board to strengthen and realign our clinical networks to provide a clear and collaborative mechanism for planning and delivery of our services across Scotland. The details will be set out in a future DL.

All NHS Boards will continue to produce their own Delivery Plans each year alongside their financial and workforce plans, and the Scottish Government will continue to issue guidance setting out its expectations around what these plans will cover.

As NHS Scotland moves to an increasingly population based approach to planning for services, the scope and nature of what individual NHS Boards plan will evolve. Future guidance on NHS Board Delivery Plans will set out in more detail the expectations around producing these plans as the national and regional planning context develops over time. Work is also underway to ensure coherence and alignment of workforce planning with these new approach.

For awareness, it is intended that a refreshed DL on Networks is issued early in 2025 which will look to set out a renewed approach to our clinical networks.

In setting out these changes and moving to a population approach to planning of services, we recognise that this will require a level of change culturally in working collaboratively. We will work with Board Chief Executives, and other system leaders, to consider how we best engage teams in working in this new way.

Key Changes and Actions
• Boards to note the establishment and roles of the NHS Scotland Executive Group, NHS Scotland Planning and Delivery Board and Strategic Planning Board in providing leadership and oversight of population level planning; • Boards to note the revised groupings for Regional working and for each Region to nominate a BCE as Regional Lead, for a minimum two year period. • National Boards to nominate BCE Lead, for a minimum two year period. • Leadership teams are asked to demonstrate a strong commitment to collaborative working and instil collaborative cultures and a common purpose within their organisations, from the frontline to the board. • To note establishment of National Planning Executive Group • To note that work is continuing on stronger alignment and refresh of Clinical Networks, which will result in a future DL. • To note the annual publication of the list of Indicative Planning Populations. • Once finalised, each Board will have a list of the services they have agreed with Scottish Government to deliver, which will ensure clarity on Scottish Government expectations of them. This will seek to include services that Boards are obliged to deliver, under enduring responsibilities, for others. • As we update the Indicative Planning Population List in future years, Regions and Boards will be asked to confirm any changes to their planning arrangements. • To note the development and application of a new Prioritisation Framework • To note the resetting of work on development of a 20-30 year Whole-System Infrastructure Plan, which will be taken forward, in the first instance, through the National Infrastructure Board. • To note the proposed new approach to commissioning and assessing proposals to deliver services.

Appendix 3

SECTION 12 (J) 1978 NHS SCOTLAND ACT.

12 J Health Boards: co-operation with other Health Boards, Special Health Boards and the Agency

(1) In exercising their functions in relation to the planning and provision of services which it is their function to provide, or secure the provision of, under or by virtue of this Act, Health Boards shall co-operate with one another, and with Special Health Boards and the Agency, with a view to securing and advancing the health of the people of Scotland.

(2) In pursuance of subsection (1) a Health Board may—

(a) undertake to provide, or secure the provision of, services as respects the area of another Health Board, and the other Health Board may enter into arrangements with the first Health Board for that purpose,

(b) undertake with one or more other Health Boards to provide, or secure the provision of, services jointly as respects their areas.

(3) A Health Board undertaking to provide, or secure the provision of, services under subsection (2) may—

(a) enter into arrangements with another Health Board, a Special Health Board or the Agency in relation to the provision of such services,

(b) do anything in relation to the provision of such services which they could do for the purpose of providing, or securing the provision of, such services as respects their area.

(4) This section is without prejudice to any other power which a Health Board may have.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Development of NHS Borders Strategy**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Author:	**Stephanie Errington, Head of Planning & Performance**

1 Purpose

This is presented to the Board for:

- Awareness and Endorsement

This report relates to a:

- NHS Borders Strategy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Our new Chief Executive in the first few months in post committed to developing a comprehensive Organisational Strategy that will guide NHS Borders' future direction. This overarching strategy will be supported by a suite of supporting and enabling strategies, with the clinical strategy being our foremost priority. We are dedicated to ensuring that these strategies are informed by meaningful discussions with our staff and communities, ensuring that every voice is heard and valued in shaping our future vision.

To start this work during January 2025 NHS Borders launched a largescale engagement exercise across all staff and Borders communities. This resulted in valuable, rich information and feedback around what NHS Borders means to our staff and public, what they value about our services and where there are opportunities for improvement.

Key themes from the engagement exercises were identified which have helped to inform the drafting of our draft Organisational Strategy (Appendix 1 & 2). This paper sets out the approach taken to develop the Strategy to date and to outline the next steps and timescales for the continued development including our Clinical Strategy and underpinning enabling Strategies so that Board members are sighted on this.

The draft Organisational Strategy will be presented for approval to an Extraordinary Board Meeting on 24th April 2025.

2.2 Background

Developing our Organisational Strategy for 2025 – 2030 will provide us with the following opportunities:

- To reconnect with our staff & public
- To understand what is important to them
- To link this back to our staff's purpose
- To provide a clear vision of where we are going, and how this links to our NHS Borders values

To provide the blueprint for our bridge towards this 2030 vision
Engagement with both staff and public across the Scottish Borders commenced on the 7th January in a variety of ways that enabled people to share their feedback and thoughts with us. We used a survey approach with five key questions that we asked staff and public, these are outlined below:

Staff Questions:

1. What do you value about working here?
2. What do you think is important and what we, at NHS Borders, do?
3. What do you think good quality healthcare looks like for you and your loved ones?
4. If there was one change you could suggest that would make a positive impact on your work here within NHS Borders, what would it be?
5. What behaviours would you **want** to see and **not** want to see at work?

Public Questions:

1. How do you keep yourself well?
2. What in your life makes it harder to keep yourself well?
3. What do you most value about the care you receive/would want to receive for your family?
4. What is the role of the NHS in the Borders?
5. What services would you value being closer to you?

To enable as many people as possible to access these questions and provide their thoughts, we developed and coordinated a range of options for people to participate:

- Focussed engagement with groups including multiple staff meetings online and in person, rotary clubs and local businesses
- Face to face conversations in public spaces to record people's views and promote the survey questions including supermarkets, libraries, leisure centres, community hubs, Borders College

- Targeted communication with groups identified through the diversity database to participate and share the engagement survey for those to share with their wider networks
- Postal option was also made available with pre-paid envelopes provided
- Electronic option for people to access the survey online through the development of a QR code and online survey link

Between the 7th January – 29th January, the Strategy Taskforce carried out 51 engagement sessions across all localities within the Scottish Borders. This included 30 sessions on NHS Borders sites, 2 leisure centres, 3 supermarkets, 3 community hubs, Borders College, 2 What Matters Hubs, 4 libraries and 2 rotary club meetings.

We also reached out to a number of local businesses and rugby clubs to ask them to circulate the questionnaire link around their staff and membership lists.

This exercise provided us with 1,347 responses.

The feedback and responses from both the staff and public engagement exercises is being used to inform the Organisational Strategy.

2.3 Assessment

NHS Borders and the services we deliver belong to the communities we serve. While we as a Board, run these services, they belong to and need to meet the needs of our communities. Therefore, to make sure we are continually delivering the right care through the right services, we need to be in conversation with those who know our services best. The Strategy will be a response to the answers we heard in our conversations and the responses to the questions we asked. The answers highlighted a number of key areas that are important to our staff and communities.

The Organisational Strategy is the first key step to setting out the direction of travel for NHS Borders for the next five years. Supporting the delivery of this will be a new Clinical Service Strategy, and new Operating Framework and a new approach to Quality Improvement.

Developing our Clinical Service Strategy

The purpose of NHS Borders is to meet the needs of our communities. For us to do this, we need to put those who are best placed to do this in the driving seat. These are those staff who meet, treat and care for our patients when they most need it, our front line clinicians and service professionals through harnessing their understanding, experience and innovation to prioritise the improvements we need to make. This will allow us to prioritise the development of our supporting services to better meet the needs of our front line services.

Developing our Internal Operating Model

In order to support the delivery of our strategies we intend to re-wire our organisation and change our internal governance and decision-making processes, building on and developing the exceptional workforce we have and enable a broader and more representative decision making which supports the effective delivery of our clinical priorities. This then allows our enabling services to better prioritise their

improvements and changes based on the needs of our clinical services meeting our community's needs.

Instilling Improvement in our Workforce

To deliver the care that our patients need, within the resource structure we have, we need to be continuously improving. Our goal is that every member of staff understands their role in achieving our organisational priorities, knows what is expected of them, receives feedback on how well they are doing, and, if there is a gap, knows how to close this through the use of improvement methodologies and techniques. Key to this will be a concerted approach to broadening the spread of quality improvement knowledge and skills, enabling every staff member to seek to make improvements to their own service areas.

These three fundamental building blocks, along with the development of wider enabling strategies, will support delivery of our overall Organisational Strategy and priority objectives over the next five years.

The timeline below outlines the key activities and workplan over the next 6 months to develop our overall Organisational Strategy, Clinical Strategy and the underpinning Enabling Strategies.

Timescale	Key activity
March 2025	Sharing of key themes and outputs back out to Staff & Public following engagement exercise undertaken during January
March & April 2025	Developing NHS Borders Draft Organisational Strategy
24th April 2025	Presenting NHS Borders Draft Organisational Strategy to NHS Borders Board meeting
May, June & July 2025	Development of NHS Borders Clinical Strategy
June & July 2025	Further engagement session with NHS Borders staff on our Values & Behaviours
August & September 2025	Development of underpinning Enabling Strategies, including, Digital, Quality, People, Property, Partnerships
October 2025	Approval of NHS Borders Organisational, Clinical and Enabling Strategies

This is an ambitious timeline, with the work impacting on all parts of our organisation. We are committed to ensuring our staff and teams are involved and engaged with the work underway and will continue to have regular dialogue with patients and staff during the development and subsequent delivery phases.

2.3.1 Quality/ Patient Care

The development of our Strategy will contribute to a more supportive and collaborative environment. This will inform the development of the Clinical Strategy to enhance the quality of patient care and lead to better health outcomes and higher patient satisfaction.

2.3.2 Workforce

The engagement with staff to date during the engagement exercise received a positive response. All comments and responses from this work have been analysed and themed and there are some great areas we want to continue to discuss along with ideas and suggestions for improvement. This feedback along with continuing conversations will help to develop and shape our People Strategy. This work will continue to give our staff the opportunity to shape the future direction of NHS Borders ensuring we have a dedicated and appropriately skilled workforce for future service delivery.

2.3.3 Financial

A financial strategy will be prepared setting out the resources available to the Health Board, the method by which these will be directed in support of the strategy, and the actions required to ensure that expenditure is aligned to the priorities outlined in the strategy and with due regard to efficiency, effectiveness and the principles of best value and value-based health and care.

2.3.4 Risk Assessment/Management

Once the strategy is developed a full risk assessment will need to be considered against the delivery and implementation plan.

2.3.5 Equality and Diversity, including health inequalities

Engaging with the public and staff is crucial for supporting the Public Sector Equality Duty the Fairer Scotland Duty, and the Board's Equalities Outcomes. Ongoing conversations will continue throughout the development and implementation of NHS Borders Strategy. As we continue with this work we will:

- Identify barriers by gathering insights from diverse groups
- Ensure that our Strategy considers the needs and experiences of all groups to inform decision making
- Continue to encourage participation from underrepresented groups to foster a more inclusive environment

2.3.6 Climate Change

Once the strategy has been developed this will require an assessment however should have a positive impact on climate change.

2.3.7 Other impacts

These will be assessed as the Strategy is developed.

2.3.8 Communication, involvement, engagement and consultation

The engagement phase during January and the ongoing development of NHS Borders Strategy has been designed through multiple discussions and groups including:

- Staff Engagement QMS Pillar
- Borders Executive Team

- NHS Borders Board Development Session
- Quality & Sustainability Board
- Engagement with Area Partnership Forum and Area Clinical Forum

2.3.9 Route to the Meeting

The development of NHS Borders Strategy and approach has been discussed across a range of groups and committees:

- Staff Engagement QMS Pillar
- BET
- NHS Borders Board Development Session
- Quality & Sustainability Board
- Senior medical staff committee
- GP sub committee

2.4 Recommendation

- The Board is asked to **Note** associated timescales for the development of NHS Borders Organisational, Clinical and Enabling Strategies

- The Board is asked to **Endorse** the approach set out in this paper to develop a clear Strategic Direction for NHS Borders for the next five years

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 - Staff Engagement Outputs – Key Themes
Appendix 2 - Public Engagement Outputs – Key Themes

NHS Borders Future Direction Staff Engagement Summary

Message from the CEO

I'd like to extend a massive thank you for your incredible response to our recent engagement roadshow. I have been pleasantly surprised by the thoughtfulness, candidness, and depth of ideas that you have put forward. The hospitality, our staff's enthusiasm and the community spirit you have shown has been genuinely uplifting. It has been heartwarming to see just how special the relationship is between NHS Borders and the community within the Borders.

The amazing level of positively-framed and constructive feedback we have received has been invaluable in informing the development of our Organisational Strategy for 2025 – 2030. As I'm sure you can appreciate, there is further work to be done, and I look forward to sharing our Strategy with you when it is ready. In the meantime, I am excited to share some initial emerging themes from the responses.

My thanks again to you for supporting this important piece of work as we shape the future of NHS Borders

Peter Moore
Chief Executive Officer
NHS Borders

What we did

During January 2025 NHS Borders launched a largescale engagement exercise across all staff and Borders communities. These conversations were set up in order to get feedback on what NHS Borders means to our staff and public, what they value about our services and where there are opportunities for improvement.

This engagement supports the development of the **Future Direction of NHS Borders** and informs our new Organisational Strategy for the next five years.

The development of this strategy will provide us with the following opportunities:

- To reconnect with our staff & public
- To understand what is important to them
- To link this back to our staff's purpose
- To provide a clear vision of where we are going, and how this links to NHS Borders values
- To provide the blueprint for our five year plan

Our aim throughout this engagement phase was to ensure that our staff and members of our communities had the opportunity to share their thoughts and shape the future direction of the organisation. We captured views by asking five questions which people could answer on a digital or paper form, and in person.

The Strategy Taskforce undertook a total of 51 engagement sessions, across a variety of locations, including:

- GP Practices • Community Hospitals
- BGH • Wards and Team Meetings
- Community Hubs • Supermarkets
- Libraries • Leisure Centres
- Swimming Pools • Rotary Club Meetings

What you said

From the five questions we asked we have captured the main points and feedback, starting with the most common responses.

Q1 What do you value about working here?

Teamwork & Support

Many respondents highlighted the importance of teamwork, collaboration, and support from colleagues as a key value in their work environment.

25%

Patient Care & Compassion

A significant number of responses emphasised the value of providing high-quality patient care and showing compassion towards patients.

20%

Sense of Community & Identity

Respondents appreciated the sense of community and identity within NHS Borders, feeling part of a close-knit organisation.

18%

Job Satisfaction & Fulfilment

Many staff members valued the sense of fulfilment and satisfaction they get from their roles, knowing they are making a positive impact.

15%

Respect & Recognition

Respect for each other and recognition for the work done were also commonly mentioned as important values.

12%

Q2 What do you think is important about what we, at NHS Borders, do?

Patient Care & Compassion

This theme emphasises the importance of providing high-quality, compassionate care to patients. It includes mentions of patient-centred care, empathy, and treating patients with dignity and respect.

28%

Health Conditions

Many responses highlight the value of working well with colleagues and other professionals, fostering a supportive and collaborative work environment.

22%

Timely & Accessible Services

This theme focuses on the need for timely access to healthcare services, reducing waiting times, and ensuring that patients receive care when they need it.

18%

Communication:

Effective communication within the organisation and with patients is a recurring theme. This includes clear, transparent communication and keeping patients informed about their care.

16%

Work Environment & Support

Responses often mention the importance of a positive work environment, including support from management, recognition of staff efforts, and opportunities for professional development.

16%

Q3 What do you think good quality healthcare looks like for you and your loved ones?

Timely Access to Care

Many respondents emphasised the importance of being seen promptly and having timely access to healthcare services.

25%

Compassionate & Respectful Care

Respondents frequently mentioned the need for healthcare providers to be compassionate, respectful,and empathetic towards patients.

20%

Effective Communication

Good communication between healthcare providers and patients, including clear explanations and regular updates, was highlighted as a key aspect of quality healthcare.

18%

Patient-Centred Care

The importance of personalised care that takes into account the individual needs and preferences of patients.

15%

Integrated & Coordinated Services

Respondents valued seamless coordination between different healthcare services and professionals to ensure comprehensive care.

12%

Q4 If there was one change you could suggest that would make a positive impact on your work here within NHS Borders, what would it be?

Improved Communication

Many respondents emphasised the importance of ongoing training need for better communication within teams between departments, and from management to staff.

18%

Increased Staffing Levels

A significant number of responses highlighted the need for more staff to reduce workload, improve patient care, and enhance overall job satisfaction.

15%

Better Training & Development

Respondents frequently mentioned the importance of ongoing training and professional development opportunities to improve skills and career progression.

12%

Enhanced Teamwork & Collaboration

Many responses focused on the need for improved teamwork and collaboration across different departments and roles to provide better patient care.

10%

Recognition & Appreciation

Several respondents expressed the desire for more recognition and appreciation for their hard work and contributions to the organisation.

8%

Q5 What behaviours would you **want** to see at work?

Respect	Teamwork	Compassion	Good Communication	Supportive
18%	16%	15%	14%	12%

What behaviours would you **not want** to see at work?

Bullying	Disrespect	Poor Communication	Blame Culture	Lack of Teamwork
15%	12%	10%	8%	7%

Overall Top 5 Themes from Staff Responses

Team Support & Collaboration

Staff highly value the supportive environment and teamwork within NHS Borders. The sense of camaraderie and working together towards common goals is a significant positive aspect of their work experience.

Commitment to Patient Care

There is a strong dedication to providing high-quality, compassionate care to patients. Staff take pride in making a positive impact on the health and wellbeing of the community.

Professional Development & Growth

Opportunities for learning, growth, and professional development are appreciated. Staff value the ability to advance their skills and careers within the organisation.

Communication & Leadership

Improved communication within teams and between different departments is a common suggestion. Staff also emphasise the need for supportive and transparent leadership that values their input and fosters a positive work environment.

Work-Life Balance & Wellbeing

Staff express the importance of maintaining a healthy work-life balance and having a supportive work environment that prioritises their wellbeing. Addressing staffing shortages and reducing workload are key areas for improvement to enhance overall job satisfaction.

What happens next?

Thank you for supporting this important piece of work as we shape the future of NHS Borders. If you have anything that you would like to feedback on from the information shown within this summary, please feel free to reach out to us at:
bor.strategy@borders.scot.nhs.uk

The themes from this engagement phase will be used to inform our Organisational Strategy for 2025 - 2023 and will also be used to support the development of our Clinical Strategy.

Thank you!

for taking the time to share your views

we received an amazing **1,347** responses in total: **565** of those were from staff and **782** were from members of the public.

NHS Borders Future Direction Public Engagement Summary

Message from the CEO

I'd like to extend a massive thank you for your incredible response to our recent engagement roadshow. I have been pleasantly surprised by the thoughtfulness, candidness, and depth of ideas that you have put forward. The hospitality, our staff's enthusiasm and the community spirit you have shown has been genuinely uplifting. It has been heartwarming to see just how special the relationship is between NHS Borders and the community within the Borders.

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This engagement supports the development of the **Future Direction of NHS Borders** and informs our new Organisational Strategy for the next five years.

The development of this strategy will provide us with the following opportunities:

- To reconnect with our staff & public
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- To link this back to our staff's purpose
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- To provide the blueprint for our five year plan

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- Community Hubs • Supermarkets
- Libraries • Leisure Centres
- Swimming Pools • Rotary Club Meetings

What you said

From the five questions we asked we have captured the main points and feedback, starting with the most common responses.

Q1 How do you keep yourself well?

Exercise
Regular physical activity such as walking, running, and going to the gym was frequently cited.

45%

Diet & Nutrition
Many respondents mentioned eating healthy foods and maintaining a balanced diet.

30%

Social Interaction
Engaging with friends, family, and community activities.

10%

Mental Wellbeing
Practices like mindfulness, meditation, and hobbies to reduce stress.

8%

Medication & Medical Advice
Following medical advice and taking prescribed medications.

7%

Q2 What in your life makes it harder to keep yourself well?

Work & Stress
Long working hours, high demands, work-life balance challenges.

40%

Health Conditions
Chronic Illnesses and physical limitations.

25%

Lack of Time
Busy schedules and family responsibilities.

15%

Family Responsibilities
Caring for children or elderly family members.

10%

Financial Constraints
The cost of healthy food and fitness activities.

10%

Q3 What do you most value about the care you receive /would want to receive for your family?

Accessibility
Easy access to healthcare services and prompt appointments.
35%

Compassionate Care
Being listened to and treated with empathy and respect.
30%

Quality of Care
High standards of medical care and professional staff.
20%

Holistic & Preventative Approach
Focus on prevention, health education and holistic approach to treatment.
10%

Continuity of Care
Seeing the same healthcare professionals for consistency.
5%

Q4 What is the role of the NHS in the Borders?

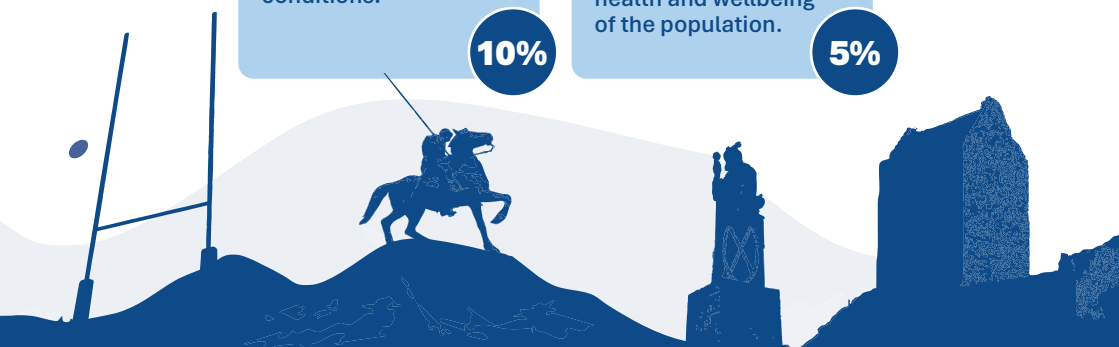
Providing Healthcare
Delivering high-quality healthcare services to the community.
40%

Prevention & Health Promotion
Encouraging healthy lifestyles and preventive care.
25%

Emergency & Critical Care
Providing emergency and critical care services.
20%

Support & Care
Offering support for both acute and chronic conditions.
10%

Community Health
Maintaining the overall health and wellbeing of the population.
5%



Q5 What services would you value being closer to you?

GP Services
More accessible general practitioners and easier appointment scheduling.
30%

Mental Health Services
Better access to mental health support.
25%

Emergency Services
A&E and minor injury units closer to home.
20%

Specialist Clinics
Services like dermatology, physiotherapy, and radiology.
15%

Preventative & Self-care Support
Self-management of health, wellness programmes and health education.
10%

Overall Top 5 Themes from Public Responses

Accessibility and Timeliness
Many respondents emphasised the importance of easy access to healthcare services and prompt appointments. They expressed concerns about long waiting times and the difficulty of getting timely care.

Quality of Care
High standards of medical care and professional staff were frequently mentioned. Respondents valued compassionate, empathetic, and respectful treatment from healthcare providers.

Mental Health Services
There was a significant demand for better access to mental health support. Many respondents highlighted the need for more mental health services and resources closer to their communities.

Holistic & Preventive Care
A comprehensive approach to healthcare that addresses both physical and mental health needs was highly valued. Respondents wanted more focus on preventive care and health promotion.

Community Health Services
The need for local clinics and community health services, such as minor injuries units and routine check-ups, was a common theme. Respondents wanted more healthcare services available within their local areas to reduce the need for travel.

What happens next?

Thank you for supporting this important piece of work as we shape the future of NHS Borders. If you have anything that you would like to feedback on from the information shown within this summary, please feel free to reach out to us at:
bor.strategy@borders.scot.nhs.uk

The themes from this engagement phase will be used to inform our Organisational Strategy for 2025 - 2023 and will also be used to support the development of our Clinical Strategy.

Thank you!

for taking the time to share your views

we received an amazing **1,347** responses in total: **565** of those were from staff and **782** were from members of the public.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Pharmaceutical Care Services Report Update**
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
- 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 Update 2025 is to provide an annual update to the approved NHS Borders Pharmaceutical Care Services Report 2024-27. This provides the Board with an update on the key challenges and recommendations listed in that report.

2.2 Background

The purpose of the Pharmaceutical Care Services 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 informs

members of the public, health professionals and planners in the planning of pharmaceutical care services.

2.3 Assessment

Information included in the 2024-27 report, highlighted some key challenges. This report provides an update to those challenges and provides an update to any recommendations made in the original report These are part of continuous improvement and development for this service.

2.3.1 Quality/ Patient Care

The report 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 updates on previous difficulties in attracting and recruiting staff, although this still has challenges for Borders, as a rural Board.

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. 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 report.

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 report updates on those topics.

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 other relevant impacts.

2.3.8 Communication, involvement, engagement and consultation

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

- The Pharmaceutical Care Services Report 2024-27 was approved by the following committees and groups before finally being approved by the Board in April 2024
- Area Pharmaceutical Committee; GP Subgroup; Public Partnership Forum; Area Clinical Forum; and Operational Planning Group.
- The report update was reviewed by Lead Pharmacist for P&CS; Pharmacy Champion and members of the Area Pharmaceutical Committee.

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.

- As above.

2.4 Recommendation

The author asks the Board to endorse the Pharmaceutical Care Services Plan report update 2025. The author also requests that the Board notes the challenges, and that 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:

- None

Pharmaceutical Care Services in NHS Borders

UPDATE - March 2025

Version: 1.0

Issue Date: March 2025

Status: FINAL

Author: Malcolm Clubb, Director of Pharmacy, NHS Borders

Table of Contents

1.0 Introduction

The Pharmaceutical Care Services Plan 2024-2027 was approved by NHS Borders in April 2024. This interim report provides an update on the key challenges and recommendations listed in that report.

Purpose of the Report

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 informs 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.

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 having been identified in the 2024-27 report. Based on current population with following exceptions, Cheviot and Tweeddale localities, the pharmacy provision is higher per head than the Scottish average.

2.0 Key Challenges Update

Some of the key challenges facing Community Pharmacies in Borders, at the time of writing this report in November 2023, are listed here with an update to the comments - March 2025.

Recommendations listed in March 2024 are also updated in the tables below.

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.

Workforce Planning Update

Following additional resource being granted by the Scottish Government, we have recruited additional staff in pharmacotherapy service. To ensure posts are filled we have required to offer remote working. This means we have been able to attract pharmacists from a wider pool. Remote pharmacists in this service have had less impact on recruiting pharmacists working in local community pharmacy.

Community pharmacy has also seen more regular pharmacists take posts within NHS Borders area. Work is on-going by independent contractors to ensure pharmacies have routine pharmacist cover. Unplanned closures, as a result of pharmacist being unavailable, have declined.

Pharmacy technicians within the pharmacotherapy service are now co-located in the Hub in Newtown St Boswells. This has fostered peer support, supervision from regular pharmacists, allowing a 52-week service for IDLs and clinic letters for GP practices as per the GMS contract.

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.

Workload - Update

Pharmacy First is available from all 29 community pharmacies in Scottish Borders. In the Pharmaceutical Care Services Report 2024-27, we reported the number of prescriptions and total cost of this service up to 2022-23. 2023-24 is available and is below with comparison to the year before. These are prescriptions going through community pharmacy instead of GP practice and are increasing each year.

Financial Year	No of prescription items dispensed - CPUS	Spend
2023 - 2024	33,651	£260,741
2022 - 2023	25,622	£186,326

Pharmacy First Plus is available from 14 independent prescribers working in 13 community pharmacies.

	Expansion of the service, led by the Scottish Government, is anticipated with more conditions covered and is expected to increase workload further.
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.	Financial – Update Settlement from the Scottish Government for 2023/24 and 2024/25 has been concluded. Negotiations are underway for 2025/26 settlement. It should be noted that the changes in national insurance contributions, outlined in the last budget, may impact on community pharmacy contractors and the service they are able to provide as they do not fall into the health exemption. Discussions are underway to see if any mitigation is available for community pharmacy contractors.
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.	Availability of medicines and devices - Update Unfortunately, we see no respite around medicines shortages and out of stocks. Teams work collaboratively to ensure patients access their medicines, or a suitable alternative, as quickly as possible. No positive update.
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.	Technology, Automation, Artificial Intelligence – Update With on-going financial uncertainty, we have seen no change locally in the implementation of technology or automation.

3.0 Recommendations Update

2024 Recommendations	Detail	**2025 Update**
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.	Promotion of the Pharmacy First Service – Update NHS Borders Communications mention community pharmacies at every possible opportunity in media releases and social media posts as part of accessing the right care in the right place messaging. This is on-going.
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.	Support and develop our network of Pharmacy First Independent Prescribers – Update Our Education & Training Lead engages on a routine basis with community pharmacy Independent Prescriber trainees. They attend Polypharmacy Clinic to achieve hours required and an opportunity to deliver care to individual patients under supervision. We must ensure that we have adequate numbers of tutors to support all pharmacists who wish to become prescribers across NHS Borders. We are keen in 2025/26 to increase support from our medical colleagues to provide training to all qualified prescribers to increase their confidence and competence in a range of conditions.
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. 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	Better access to patient clinical records – Update We await changes in GP clinical systems in 2025/26 to find out about opportunities for community pharmacists to view access to relevant sections of patient medication records. At the moment, no progress can be made in this area.

	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.	Promote improved working relationships between independent contractors – Update NHS Borders Pharmacy Champion noted that less face-to-face interaction, and sharing of useful intelligence with GPs, is regrettable but the way of communications now. Community pharmacist at West Linton has noted that "hub working for Pharmacotherapy teams has given direct access to an able team of clinicians that can help with admin around prescription queries, discharges on more days than before when it was practice based. We all play our part in the delivery of high-quality pharmaceutical care, and effective partnerships with efficient communications are crucial to this." The Pharmacotherapy team are in the process of surveying the practices and community pharmacists to ensure that they are satisfied with the service provided from the Hub and will arrange 1-2-1 visits for any that need further discussion.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Risk Appetite Policy**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality and Improvement**
Report Author:	**Lettie Pringle, Risk Manager**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

Following the implementation of the Blueprint for Good Governance the risk appetite has been reviewed and updated to align with the Orange Book issued by the UK Government. The NHS Borders Healthboard approved the Risk Appetite Policy and statement in January 2024.

It is good practice to review the risk appetite statements annually.

Risk Appetite is a matter reserved for the Health Board as per the Code of Corporate Governance and as such the Health Board are being asked to approve the revised Risk Appetite Statements for 25/26 as included in appendix 1.

2.2 Background

The risk appetite of NHS Borders has been established to provide a framework which enables NHS Borders to make informed decisions on which risks to mitigate by defining tolerable risk levels.

The benefits of adopting the risk appetite include:

- Supporting informed decision-making
- Reducing uncertainty
- Improving consistency across governance mechanisms and decision-making
- Supporting performance improvement
- Focusing on priority areas within NHS Borders
- Informing spending reviews and resource prioritisation processes

2.3 Assessment

Within NHS Borders, the nature of the services provided, changing external demands and fiscal constraints mean it is neither feasible nor practical to fully prevent or mitigate all risks at any point in time.

Risk appetite statements help to inform resource allocation at decision points, and additionally when the organisation periodically reviews its performance.

To gain consistency in the risk management decisions taken across NHS Borders, the risk appetite statements highlight the total risk that NHS Borders can tolerate within its risk profile.

Following review of statements by the Board Executive Team and Audit and Risk Committee, a suggested revision to two risk appetite statements; finance and reputation is being put forward for approval.

2.3.1 Quality/ Patient Care

The Risk Appetite Statements allow risk owners across the organisation to follow a consistent approach to managing significant risks affecting quality and patient care by providing parameters in the risk-taking approach deemed acceptable by NHS Borders and allowing informed decisions to be made based on risk exposure.

2.3.2 Workforce

The Risk Appetite Statements allow risk owners across the organisation to follow a consistent approach to managing significant risks affecting the workforce by providing parameters in the risk-taking approach deemed acceptable by NHS Borders and allowing informed decisions to be made based on risk exposure.

2.3.3 Financial

The Risk Appetite Statements allow risk owners across the organisation to follow a consistent approach to managing significant risks affecting finances by providing parameters in the risk-taking approach deemed acceptable by NHS Borders and allowing informed decisions to be made based on risk exposure.

2.3.4 Risk Assessment/Management

These statements will form part of the Risk Appetite Policy which will support the NHS Borders Risk Management Strategy and the NHS Borders Risk Management Policy.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment (stage one) has been completed and is available as appendix 2.

Previous HIIA remains relevant.

2.3.6 Climate Change

The Risk Appetite Statements allow risk owners across the organisation to follow a consistent approach to managing significant risks affecting climate change by providing parameters in the risk-taking approach deemed acceptable by NHS Borders and allowing informed decisions to be made based on risk exposure.

2.3.7 Other impacts

No other relevant impacts.

2.3.8 Communication, involvement, engagement and consultation

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

2.3.9 Route to the Meeting

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

- Board Executive Team, 18th March 2025

2.4 Recommendation

- **Decision** – The Board are asked to **approve** the revision to the risk appetite approach for Governance, Finance and Reputation as detailed in Appendix 1.

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, Risk Appetite Statements
- Appendix 2, Risk Appetite Policy

Appendix 1: NHS Borders Risk Appetite Statements and Approach 2025/26

	Risk Appetite Statement	Risk Approach	Recommended Approach 2025/26
Strategy	NHS Borders has an **eager** stance to risks arising from the pursuit of their strategic objectives, recognising the scale of transformation required to sustain health services.	Eager	REMAIN UNCHANGED
Governance	NHS Borders takes a **cautious** stance to governance and is receptive to making and acting upon difficult decisions when the benefits outweigh the risks when clear plans/priorities/accountabilities are in place and where decision-making oversight is proportionate and effective.	Cautious	REMAIN UNCHANGED
Operations	NHS Borders has an **open** stance to delivering services supported by innovative solutions and supports decision-making at local level where there is a positive impact on financial sustainability and patient and staff safety.	Open	REMAIN UNCHANGED
Legal	NHS Borders has a **minimal** stance to risks arising from a defective transaction or a claim being made (including a defence to a claim or a counterclaim).	Minimal	REMAIN UNCHANGED
Compliance	NHS Borders has adopted a **minimal** stance for compliance, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk as far as reasonably practicable within given capacity. This includes risks arising from inadequate, poorly designed, or ineffective/inefficient internal processes resulting in poor quality care, unacceptable risk to patients or staff, non-compliance with standards, poor clinical / professional practice, fraud, error and/or poor value for money.	Minimal	REMAIN UNCHANGED
Financial	Our financial decisions are heavily scrutinised, with value for money being a key factor in decision-making. We will accept risks that may result in some very limited financial loss or exposure on the basis that these can be expected to balance out but will not accept financial risks that could result in significant reprioritisation of budgets. As such, NHS Borders has adopted a **minimal** stance for financial risks regarding business as usual, seeking safe delivery options with little residual risk that can only yield some upside opportunities.	Minimal	PROPOSE A CHANGE OF STANCE TO CAUTIOUS
Competence	NHS Borders has a **minimal** stance to risks arising from the unavailability of sufficient capability or non-compliance resulting in negative impacts on service performance and NHS Borders values. This stance supports informed risk taking in the further development of staff skills where professional statutory and mandatory training requirements are fulfilled in line with their job role responsibilities.	Minimal	REMAIN UNCHANGED
People	NHS Borders has a **cautious** stance to risks that affect staff wellbeing, particularly when service delivery is compromised. NHS Borders is committed to ensuring that safe staffing levels are maintained where capacity and resource allows.	Cautious	REMAIN UNCHANGED
	Risk Appetite Statement	**Risk Approach**	
Technology	NHS Borders has adopted an **open** stance to technological risks where proven technologies are considered to enable improved operational delivery.	Open	REMAIN UNCHANGED
	An **averse** stance is taken for any risks relating to cyber security, technological fraud and inadvertent or malicious corruption/modification of data on its IT systems.	Averse	REMAIN UNCHANGED
Information	NHS Borders has adopted a varied stance to information risk, to reflect the sensitivity of information as defined by NHS Scotland Information Classification. All risks relating to information should adhere to the NHS Borders information governance policies.		

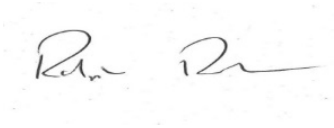
	- Tier 1 (Unclassified/Personal): NHS Borders has adopted a **minimal** stance to limit the potential damage from disclosure of information; - Tier 2 (Protected/ Official): NHS Borders has adopted an **open** stance, given the need for operational effectiveness, and with risk mitigated through careful drafting and/or limiting distribution; - Tier 3 (Highly Sensitive/ Official Sensitive): NHS Borders has adopted an **averse** stance where there will be no tolerance to disclosure of information that would lead to serious risks to the organisation.	Minimal Open Averse	REMAIN UNCHANGED REMAIN UNCHANGED REMAIN UNCHANGED
Premises	NHS Borders takes a **minimal** stance to any risks that fail to comply with strict policies for purchase, rental, disposal and construction that ensures producing good value for money. NHS Borders takes an **open** stance to refurbishment where benefits outweigh the risks and innovative solutions can be realised.	Minimal Open	REMAIN UNCHANGED REMAIN UNCHANGED
Commercial	NHS Borders takes an **open** stance to risks where commercial partnerships, supply chains and contractual requirements can be strengthened. Innovation is supported with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	Open	REMAIN UNCHANGED
Security	NHS Borders takes a varied approach to security risks. NHS Borders has adopted a **minimal** stance to risks causing loss or damage to property, assets, information, or people and are strictly controlled through adherence to policy and procedures. For risks relating to building security NHS Borders takes a **cautious** stance to support organisational needs for public access to services, with appropriate monitoring measures in place.	Minimal Cautious	REMAIN UNCHANGED REMAIN UNCHANGED
Inequalities	NHS Borders has adopted a **minimal** stance to inequality risks, ensuring that the majority of patients receive the same quality of care, at the correct time, in the correct manner.	Minimal	REMAIN UNCHANGED
Project/ Programme	NHS Borders has an **open** approach to project risks to ensure that they are aligned with strategic priorities within the Medium-Term Plan and successfully and safely deliver requirements and intended benefits regarding time, cost and quality.	Open	REMAIN UNCHANGED
Reputational	NHS Borders has adopted an **open** stance for risks allowing for informed decisions that have the potential to expose the organisation to additional medium to long term scrutiny, but only where potential benefits outweigh the risks.	Open	PROPOSE A CHANGE OF STANCE TO EAGER

Risk Approach	Definition	Actions Required
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is the key objective.	Risk managed with a robust action plan. No tolerance to risk with a very high risk level.
Minimal	Preference for very safe business delivery options with the potential for benefit/return not a key driver.	Risk managed with a robust action plan. Will tolerate risks for 3 months whilst risk is being mitigated/ reduced to an acceptable level.
Cautious	Preference for safe options and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity.	Risk managed with a robust action plan. Will tolerate risks for 6 months whilst risk is being mitigated/ reduced to an acceptable level.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.	Risk managed with a robust action plan. If risk controls cannot be introduced due to lack of resource and its dependence on external factors the risk may be tolerated. An update should be given on progress to the Operational Planning Group within a specified timescale.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.	Risk managed with a robust action plan in place to ensure success. Risk may be tolerated. An annual update should be given on progress to the Operational Planning Group. Residual risks with a very high risk level should be considered through the risk appetite process separately.

NHS Borders Risk Appetite Policy

File Name:	Risk Appetite Policy
Version Number:	V1.3
Status:	Approved
Prepared By:	Risk Team
Distribution date:	February 2024
Review date:	February 2026
Distribution arrangements:	Intranet

This policy has been approved for NHS Borders



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Chief Executive

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Employee Director

Approval date: 2023
Authorisation date: 2023

VERSION HISTORY

Release	Date	Author	Comments
Draft 1.0	17th August 2023	Risk Team	1st draft
Draft 1.1	14th September 2023	Risk Team	Amendments following comments
Draft 1.2	28th December 2023	Risk Team	Amendments after statement comments at BET/Board Development Session
V1.3	19th March 2025	Risk Team	Amendments following statement reviews for 25-26

AUTHORISING CONTROL

Document Control

Document Name: Risk Appetite Policy
Version Number: v1.3
Date Created: 17th August 2023
Date Last Amended: 19th March 2025
Approved By: *Operational Planning Group, Board Executive Team*
Authorised By: *Healthboard*

Term	Intention
shall	denotes a requirement: a mandatory element
should	denotes a recommendation: an advisory element
may	denotes approval
might	denotes a possibility
can	denotes both capability and possibility
is/are	denotes a description

Contents

Table of Diagrams

1 Introduction

1.1 Risk management is an integral part of good governance and corporate management mechanisms. An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to exploit opportunities and to take managed risks, not simply avoid risks altogether, and systematically anticipates and prepares successful responses.

1.2 Risk appetite statements are key enablers to communicating expectations and ensuring effective decision-making. They should be considered robustly and consistently across NHS Borders. In addition, their consideration may form evidence to inform and support financial planning, financial improvement plans, investment and budget allocation processes.

1.3 This Policy should be used alongside the Risk Management Policy and the Risk Fund Framework.

A. Risk Appetite

2 Definitions

2.1 Risk Appetite

2.1.1 Risk appetite is defined as the "amount and type of risk that an organisation is willing to pursue or retain". [1]

2.1.2 Within NHS Borders, the nature of the services provided, changing external demands and fiscal constraints mean it is neither feasible nor practical to fully prevent or mitigate all risks at any point in time.

2.1.3 The risk appetite of NHS Borders has been established to provide a framework which enables NHS Borders to make informed decisions on which risks to mitigate by defining tolerable risk levels.

The benefits of adopting the risk appetite include:

- Supporting informed decision-making
- Reducing uncertainty
- Improving consistency across governance mechanisms and decision-making
- Supporting performance improvement
- Focusing on priority areas within NHS Borders
- Informing spending reviews and resource prioritisation processes

2.1.4 To gain consistency in the risk management decisions taken across NHS Borders, the organisation will use the risk statements within this policy.

2.1.5 Organisational risk appetite statements highlight the total risk that NHS Borders can tolerate within its risk profile and provide a structure for NHS Borders to work within.

2.1.6 Risk appetite statements help to inform resource allocation at decision points, and additionally when the organisation periodically reviews its performance.

2.2 Risk Tolerance

2.2.1 Risk tolerance is "an organisation's readiness to bear the risk after risk treatment in order to achieve its objectives".[1] This relates to the risk level that can be tolerated for each individual risk type.

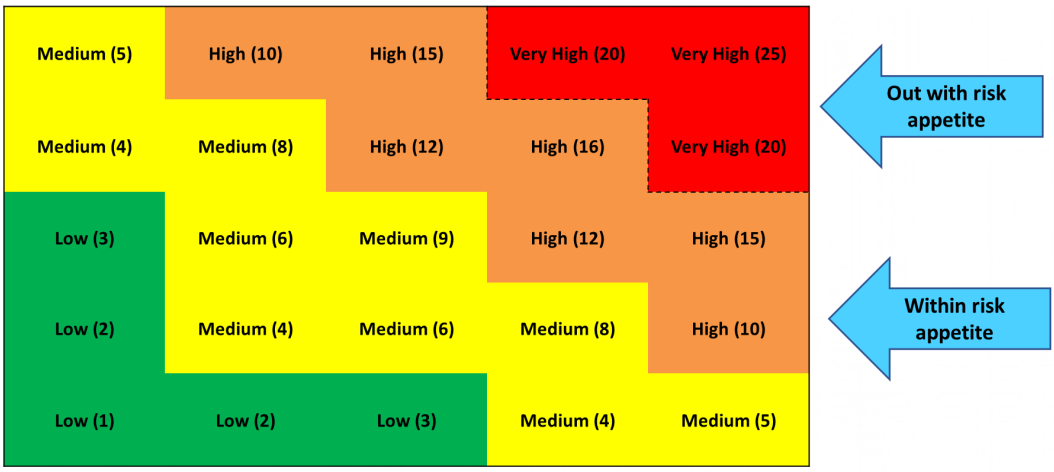
[1] (ISO Guide 73:2009 Risk Management – Vocabulary).

2.2.2 Risk tolerance is a term that can be defined as an informed decision to accept the consequences and likelihood of a particular level of risk following implementation of an action plan.

2.2.4 The risk appetite process provides greater clarity on the risks NHS Borders wants to manage and those that can be tolerated. It sets the tone from the top for the risk culture across the organisation, ensuring there is a clear message that reflects NHS Borders visions and goals. It ensures that the actual risks are articulated to the organisation and informed decisions can be made.

2.2.5 All risks on the strategic risk register are overseen by the Board Executive Team, and the same risk appetite applies.

2.2.6 Any risks graded as very high risks will follow the risk appetite process.



3 Risk appetite to support effective decision making

3.1 The consequences of a decision being considered might impact several areas, perhaps even in a particular order, and require staff to weigh risks against each other in order to support effective decision making.

3.2 When weighing risks against each other, the organisation shall document what was considered at the time to inform the decision and the balance within the judgment made.

3.3 When decisions are made outside of appetite their justification and evidence should be recorded and reported following the risk management escalation process (**Appendix 1**). If a decision recognised as being outside of appetite is considered necessary, and is appropriately authorised and approved, it will require specific monitoring by the Operational Planning Group, and if necessary the Board Executive Team.

4 Exceptions

4.1 As organisations consider and maintain their risk appetite to reflect context and changing environmental factors, there may be circumstances, such as those experienced dealing with government's response to the Covid-19 crisis, when it becomes necessary to significantly alter the level, nature and balance of risks with which an organisation is willing, or required, to operate to deliver public services for a period of time.

4.2 Where this occurs, it is important that there is openness and transparency of these decisions and arrangements, active monitoring and reporting of consequences and clarity over recovery actions. If the circumstances are expected to endure, if only temporarily, then the Board Executive Team should consider re-stating its risk tolerance levels and review regularly. Likewise if there is a significant deviation from the risk appetite statements, the Health Board should consider reviewing these.

B. NHS Borders Risk Appetite

5 Organisational Risk Appetite Statements for all risks

5.1 All risks will be managed within statutory requirements.

5.2 Clinical risks will be managed in accordance with good clinical practice and clinical governance standards. Clinical risk owners should involve other stakeholders as appropriate.

5.3 Financial risk will be managed to corporate standards and financial policies.

5.4 All risks will be assessed using the electronic risk management system that informs the risk register. Any loss of service/resilience issues/ threats to corporate objectives must be proactively risk assessed and entered on the risk register and, where appropriate, business continuity plans put in place.

6 Risk Appetite Process

6.1 The process is a two-stepped approach whereby any risks graded as very high use the risk appetite process, including risk management approaches, to determine whether a very high risk is outwith organisational risk appetite. Risks deemed outwith risk appetite are highlighted by the risk owner on the risk register and these are then fed into the Operational Planning Group. The current risk appetite to certain types of risks is outlined in **Diagram 4**.

6.2 The Risk Appetite Process still allows risk owners to bring any level of risk on an ad hoc basis to the Operational Planning Group should they decide it requires support at a higher level.

7 Operational Risk

7.1 Very High Operational Risks

7.1.1 It is vital that the risk escalation process (**Appendix 1**) has been followed prior to reporting a very high risk to the Operational Planning Group:

- When a very high risk is identified at a local level, an action plan shall be put in place that is within the remit of that risk owner and the target risk level this will achieve shall be identified;
- If this action plan is unable to reduce the risk level, this should be escalated to the Line Manager who will develop an action plan within their remit to reduce the risk to the target risk level;
- If, after this, the risk level still cannot be reduced, this should be escalated to the quadrumvirate/ Corporate Services Meeting to ensure no additional support can be given before this is escalated to the Operational Planning Group.

7.1.2 As part of the scrutiny provided by the Operational Planning Group (or alternative if deemed appropriate) on whether to invest in mitigating risks, it is important for the membership to review the target risk level. If the target risk level is within risk appetite, the Operational Planning Group may decide that investment is not required following completion of actions put in place.

7.1.3 Where the target level still reflects a very high risk, the Operational Planning Group will be required to scrutinise the actions put in place to decide whether these are sufficient. If they are not, it is within the Operational Planning Groups responsibility to ask for a more robust action plan to be developed by the risk owner and monitor this risk within a time bound plan to ensure actions are being progressed.

7.1.4 If the actions are sufficient and robust, the Operational Planning Group will decide whether investment from the risk fund is the best solution to mitigate this risk or whether further escalation to the Board Executive Team is required.

7.2 High Operational Risks

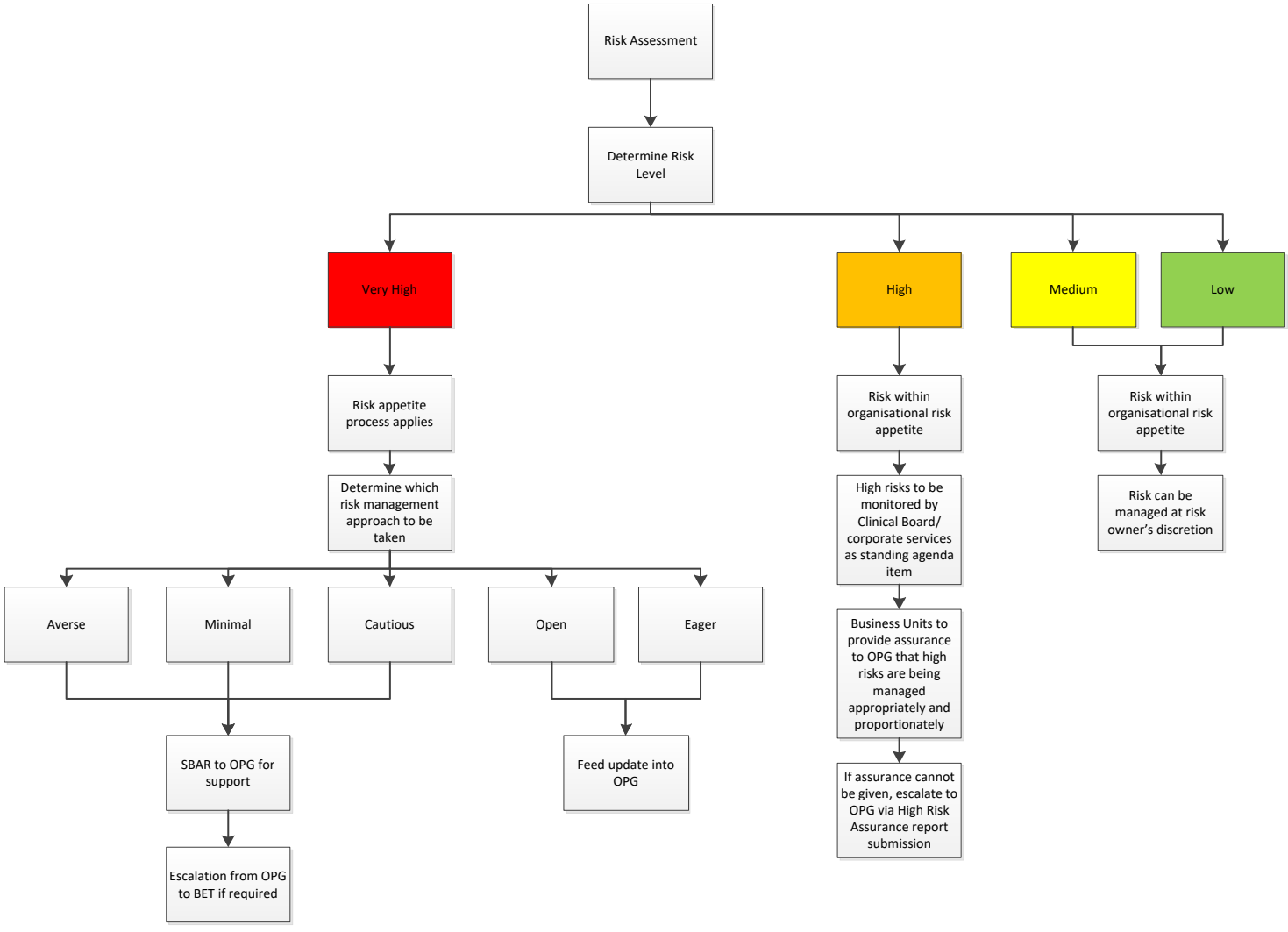
7.2.1 Governance of high risks will be achieved through business units as standing items on Clinical Board/ Corporate Services agendas. These groups will have the responsibility for oversight of high risks within their areas and will require assurance these are being managed appropriately and proportionately.

7.2.2 To support this work, reports on very high and high risks will continue to be fed into the Audit and Risk Committee and Clinical Governance Committee.

7.3 Medium/ Low Operational Risks

7.3.1 Medium and low risks should be managed locally by the risk owner and their management team to ensure that risks are not escalating and any actions are progressed as required.

Diagram 1: Risk appetite process - operational risks



8 Strategic Risk

8.1 Very High Strategic Risks

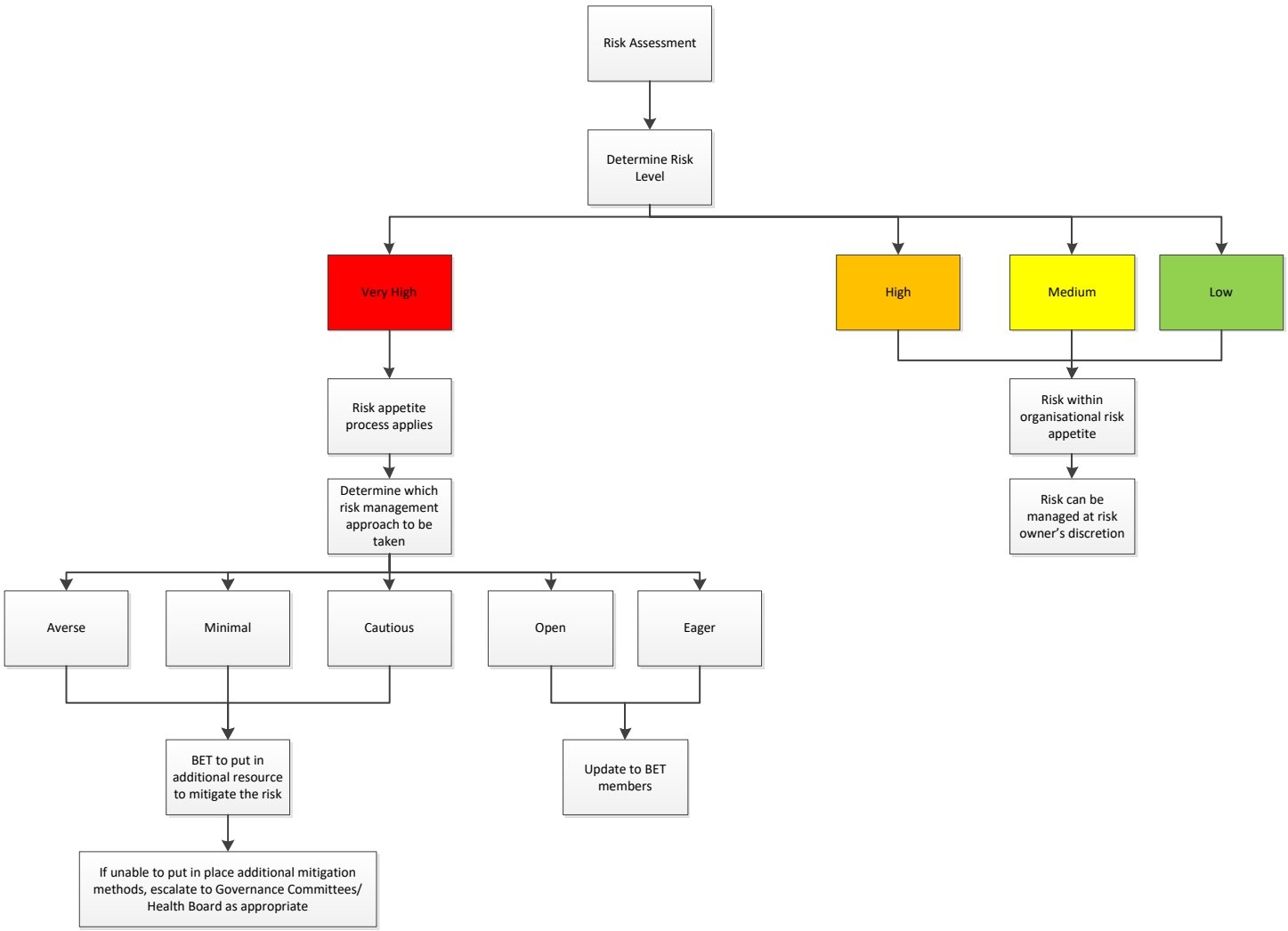
8.1.1 The Board Executive Team should scrutinise risks belonging to other members of the Board Executive Team to ensure that adequate resource is in place to mitigate risk. If it is deemed appropriate and mitigation is not possible, these risks should be escalated to the appropriate Governance Committee/Health Board.

8.1.2 Strategic risks within organisational risk appetite will continue to be fed into the Board Executive Team and Governance Committees as per agreed Committee work plans.

8.2 High, Medium and Low Strategic Risks

8.2.1 High, medium and low strategic risks should be managed locally by the risk owner and their management team to ensure that risks are not escalating and any actions are progressed as required

Diagram 2: Risk appetite process - strategic risks



9 Risk Approach

9.1 The risk approach outlines how the organisation will manage risks outwith the appetite.

9.2 Risks shall be assessed against the risk approach to decipher whether there is flexibility in the category of risk reported, before confirming whether it is within, or outwith, risk appetite.

9.3 It gives flexibility to those risks outwith organisational risk appetite where risk owners can use their discretion to manage a risk down in a set timeframe. Risk owners are given flexibility to put resources into reducing risk levels with the expectation there will be a robust action plan in place to do so within a set timeframe. The current risk approaches are positioned to protect the organisation from risks that could cause damage whilst still allowing positive risk taking to be undertaken to ensure opportunities are realised.

9.4 A decision by the risk owner on how to manage the risk shall be taken to the Operational Planning Group to agree an approach to minimise the risk.

Diagram 3: NHS Borders Risk Management Approach

Risk Approach	Definition	Actions Required
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is the key objective.	Risk managed with a robust action plan. No tolerance to risk with a very high risk level.
Minimal	Preference for very safe business delivery options with the potential for benefit/return not a key driver.	Risk managed with a robust action plan. Will tolerate risks for 3 months whilst risk is being mitigated/ reduced to an acceptable level.
Cautious	Preference for safe options and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity.	Risk managed with a robust action plan. Will tolerate risks for 6 months whilst risk is being mitigated/ reduced to an acceptable level.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.	Risk managed with a robust action plan. If risk controls cannot be introduced due to lack of resource and its dependence on external factors the risk may be tolerated. An update should be given on progress to the Operational Planning Group within a specified timescale.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.	Risk managed with a robust action plan in place to ensure success. Risk may be tolerated. An annual update should be given on progress to the Operational Planning Group.

	Residual risks with a very high risk level should be considered through the risk appetite process separately.

Diagram 4: Risk Category - Appetite Statements

	Risk Appetite Statement	Risk Approach
Strategy	NHS Borders has an **eager** stance to risks arising from the pursuit of their strategic objectives, recognising the scale of transformation required to sustain health services.	Eager
Governance	NHS Borders takes a **open** stance to governance and is receptive to making and acting upon difficult decisions when the benefits outweigh the risks when clear plans/priorities/accountabilities are in place and where decision-making oversight is proportionate and effective.	Cautious
Operations	NHS Borders has an **open** stance to delivering services supported by innovative solutions and supports decision-making at local level where there is a positive impact on financial sustainability and patient and staff safety.	Open
Legal	NHS Borders has a **minimal** stance to risks arising from a defective transaction or a claim being made (including a defence to a claim or a counterclaim).	Minimal
Compliance	NHS Borders has adopted a **minimal** stance for compliance, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk as far as reasonably practicable within given capacity. This includes risks arising from inadequate, poorly designed, or ineffective/inefficient internal processes resulting in poor quality care, unacceptable risk to patients or staff, non-compliance with standards, poor clinical / professional practice, fraud, error and/or poor value for money.	Minimal
Financial	Our financial decisions are heavily scrutinised, with value for money being a key factor in decision-making. We will accept risks that may result in some very limited financial loss or exposure on the basis that these can be expected to balance out but will not accept financial risks that could result in significant reprioritisation of budgets. As such, NHS Borders has adopted a **cautious** stance for financial risks regarding business as usual, seeking safe delivery options with little residual risk that can only yield some upside opportunities.	Cautious
Competence	NHS Borders has a **minimal** stance to risks arising from the unavailability of sufficient capability or non-compliance resulting in negative impacts on service performance and NHS Borders values. This stance supports informed risk taking in the further development of staff skills where professional statutory and mandatory training requirements are fulfilled in line with their job role responsibilities.	Minimal
People	NHS Borders has a **cautious** stance to risks that affect staff wellbeing, particularly when service delivery is compromised. NHS Borders is committed to ensuring that safe staffing levels are maintained where capacity and resource allows.	Cautious

	Risk Appetite Statement	Risk Approach
Technology	NHS Borders has adopted an **open** stance to technological risks where proven technologies are considered to enable improved operational delivery.	Open
	An **averse** stance is taken for any risks relating to cyber security, technological fraud and inadvertent or malicious corruption/modification of data on its IT systems.	Averse
Information	NHS Borders has adopted a varied stance to information risk, to reflect the sensitivity of information as defined by NHS Scotland Information Classification. All risks relating to information should adhere to the NHS Borders information governance policies.	
	- Tier 1 (Unclassified/Personal): NHS Borders has adopted a **minimal** stance to limit the potential damage from disclosure of information;	Minimal
	- Tier 2 (Protected/ Official): NHS Borders has adopted an **open** stance, given the need for operational effectiveness, and with risk mitigated through careful drafting and/or limiting distribution;	Open
	- Tier 3 (Highly Sensitive/ Official Sensitive): NHS Borders has adopted an **averse** stance where there will be no tolerance to disclosure of information that would lead to serious risks to the organisation.	Averse
Premises	NHS Borders takes a **minimal** stance to any risks that fail to comply with strict policies for purchase, rental, disposal and construction that ensures producing good value for money.	Minimal
	NHS Borders takes an **open** stance to refurbishment where benefits outweigh the risks and innovative solutions can be realised.	Open
Commercial	NHS Borders takes an **open** stance to risks where commercial partnerships, supply chains and contractual requirements can be strengthened. Innovation is supported with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	Open
Security	NHS Borders takes a varied approach to security risks.	
	NHS Borders has adopted a **minimal** stance to risks causing loss or damage to property, assets, information, or people and are strictly controlled through adherence to policy and procedures.	Minimal
	For risks relating to building security NHS Borders takes a **cautious** stance to support organisational needs for public access to services, with appropriate monitoring measures in place.	Cautious

	Risk Appetite Statement	Risk Approach
Inequalities	NHS Borders has adopted a **minimal** stance to inequality risks, ensuring that the majority of patients receive the same quality of care, at the correct time, in the correct manner.	Minimal
Project/ Programme	NHS Borders has an **open** approach to project risks to ensure that they are aligned with strategic priorities within the Medium-Term Plan and successfully and safely deliver requirements and intended benefits regarding time, cost and quality.	Open
Reputational	NHS Borders has adopted an **eager** stance for risks allowing for informed decisions that have the potential to expose the organisation to additional medium to long term scrutiny, but only where potential benefits outweigh the risks.	Eager

C. Governance

10 Escalation and Governance of risks within risk appetite process

10.1 The escalation and governance of risks, both within and outwith risk appetite, at certain risk levels will feed into and inform current work relating to implementation of a simplified decision-making structure and levels of authority to support the Quality Management System drivers for Business Processes.

Diagram 5: Operational risk escalation and governance

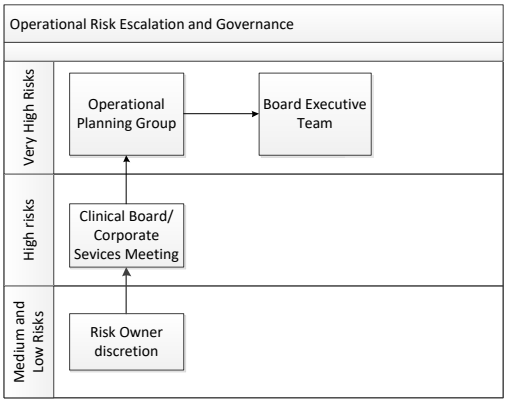
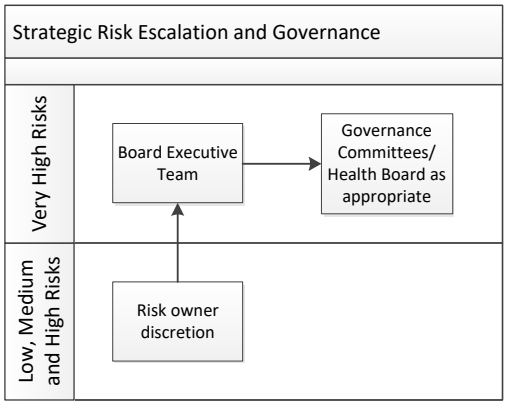


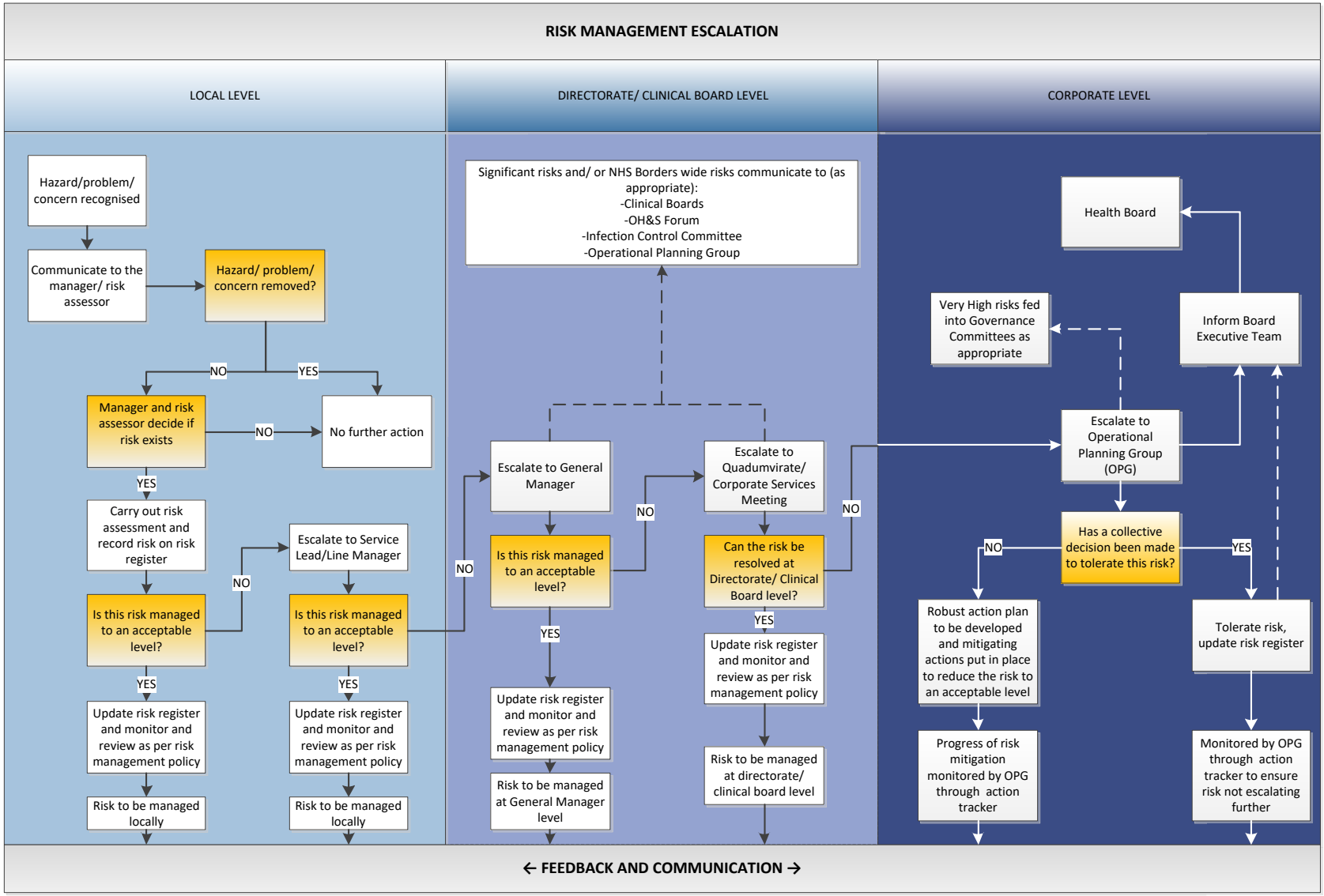
Diagram 6: Strategic risk escalation and governance



11 Internal Audit

11.1 As a key part of the risk management framework and to inform an opinion on the adequacy and effectiveness of governance, risk management and internal control, it is likely that NHS Borders internal auditors will want to review how its risk appetite statements are applied in practice within decision-making. For this reason it is important that Risk Owners and the Operational Planning Group document the factors influencing the decisions they make to ensure transparency and are able to demonstrate the exercise of judgment in seeking to deliver value for money.

Appendix 1 – Risk Escalation Process



NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Resources & Performance Committee Minutes**
Responsible Executive/Non-Executive:	**Peter Moore, 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 6 March 2025.

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 16.01.25

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 16 January 2025 at 9.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs L O'Leary, Non Executive
Mr J Ayling, Non Executive
Mrs L Livesey, Non Executive
Cllr D Parker, Non Executive
Mr J McLaren, Non Executive
Mr P Moore, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Mr A Carter, Director of HR
Mr C Myers, Chief Officer, Health & Social Care
Mrs J Smyth, Director of Planning and Performance
Mrs L Jones, Director of Quality & Improvement
Dr S Bhatti, Director of Public Health
Mrs L Huckerby, Interim Director of Acute Services

In Attendance:
Mrs L Goodman, Head of IM&T
Mr K Bryce, Programme Manager IM&T
Ms S Thomson, Information Governance & Cyber Assurance Manager
Dr C Kelly, Consultant Physician General Medicine
Mr C Cowan, Resilience Manager
Mrs C Lyall, Senior Planning & Performance Manager
Ms L Henderson, Communications Officer

1. Apologies and Announcements

1.1 Apologies had been received from Mrs F Sandford, Non Executive, Mrs H Campbell, Non Executive, Dr K Buchan, Non Executive, Miss I Bishop, Board Secretary and Mrs S Horan, Director of Nursing, Midwifery & AHPs.

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

1.4 The Chair confirmed the meeting was quorate.

2. Declarations of Interest

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

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

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Resources and Performance Committee held on 7 November 2024 were approved.

4. Matters Arising

4.1 **Action: 2024-4:** Mrs Lynne Huckerby advised the Committee that the go live for June remained on track with both project and resource plans in place. She remained connected to the other Health Boards who were in a similar position to ensure all were united in terms of Clinisys engagement. Confirmation was awaited from Clinisys to clarify their position beyond March. In terms of UCAS Accreditation additional support had been secured to progress the recommendations and the Laboratory service were undertaking a wider service review.

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

5. Digital Foundations Refresh Programme

5.1 Mrs June Smyth provided a brief overview of the content of the report and highlighted that a fuller update would be provided to the next meeting in regard to strategic risk.

5.2 Mrs Laine Goodman commented on the draft recommendations from audits and assessments and the inability to prioritise those and failure to secure organisational investment to address them historically.

5.3 Discussion focused on: draft recommendations from external reports and assessments; organisational investment; welcome the setting out of workstreams of what needs to be achieved; translating the messages to our wider workforce; digital engagement development with staff; organisational development for the digital team; staff engagement plan: timelines and implementation of the programme; Scottish Government assessment reaffirmed the risks we were aware of; lessons to be learnt; welcome as a signpost for the way ahead; reconcile risk with financial position; digital strategy to prioritise alongside the organisational strategy; clarify that we asked the Scottish Government to provide us with insight and support in this area; and recognition that it is an interim report.

5.4 The Chair reminded the Committee that the report was an interim report, presented to the Committee for awareness and a fuller report would be received at a future meeting.

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

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received limited assurance from the report.

6. Performance Report

6.1 Mrs June Smyth provided an overview of the content of the report and highlighted the poor performance to date and the performance aims for next year.

6.2 Discussion focused on: cross cutting theme of staffing issues such as sickness absence, recruitment, vacancies, statutory and mandatory training targets, appraisal targets; more staff in the organisation than in the past and yet meeting after meeting we report declining performance; £1m investment in the Emergency Department and to date no improvement in performance in that area; focused performance and quality discussion at the start of every Board Executive Team weekly meeting; upward trajectory for statutory and mandatory training over the past year; more reporting on appraisal and PDP compliance; adults with neurodevelopmental disorders we supported the service to prioritise those at greatest clinical risk; movement towards more integrated performance reports to include key themes and triangulation of information; and triangulation of staff data appeared to cause difficulties for services and would be welcomed in future reports.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the performance to end of November 2024.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed that future reports in the next financial year should contain a triangulation of data on cross cutting workforce impacts.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received limited assurance from the report.

7. Strategic Risk: Emergency Planning and Resilience

7.1 Mrs June Smyth provided a brief overview of the content of the report and highlighted: assessments; mitigations to address risks; revised Emergency Planning Resilience policy; move from compliance to cultural resilience; and move to a more proactive approach.

7.2 Discussion focused on: strategic leadership to resilience which would be better provided through a permanent position; and a general observation on longer term impact assessments and a surveillance system that might be built in for future generations.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the strategic risk, as well as the work that was being carried out in order to mitigate said risk.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed that it be provided with an overview on progress with the Resilience Manager post via the Action Tracker.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received limited assurance from the report.

8. Finance Report

8.1 Mr Andrew Bone provided a brief overview of the content of the report and highlighted that it confirmed the position to the end of November 2024; the organisation remained on track as forecast; confirmation had been received that brokerage had been increased to cover the full forecast deficit; and the progression of savings schemes had slowed as previously predicted.

8.2 Discussion focused on: the slowdown in identified savings was as expected due to a reduction in the number of new programmes and projects flowing through the pipeline for delivery; maintaining discipline around the Financial Improvement Programme (FIP); route to escalate potential impact of savings causing harm or impacting patient welfare; every individual savings scheme is risk assessed and impact assessed before implementation and if any risks are identified they are escalated through the management line in the first instance; cost and workforce and activity triangulation; governance structure change; innovative cost savings in the past; and the quality improvement approach to become more efficient.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the contents of the report including the following:

YTD Performance	£12.77m overspend
Outturn Forecast at current run rate	£19.15m overspend
Q2 Review Forecast (adjusted trend)	£21.05m overspend
Variance against Plan (at current run rate)	£6.61m improvement
Projected Variance against Plan (Q2 Forecast)	£1.90m underspend
Actual Savings Delivery (current year effect)	£7.84m (actioned)
Projected gap *to SG brokerage*	Best Case £4.35m (trend) Worst Case £6.25m (M08)

The **RESOURCES & PERFORMANCE COMMITTEE** noted the assumptions made in relation to Scottish Government allocations and other resources.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received moderate assurance from the report.

9. Annual Delivery Plan 2025/26

9.1 Mrs June Smyth provided an overview of the report and highlighted: the delay in receipt of Scottish Government guidance and timelines; good engagement had taken place with services and there were still some areas to be completed.

9.2 Mr Peter Moore commented that he would be discussing with the Scottish Government areas where the organisation did well, where it would be best to put its efforts and that there may be some aspects of the Annual Delivery Plan that the organisation would potentially step back from. Obviously there would be a concerted effort to achieve what the organisation had been asked to achieve, but there would be areas where the organisation would not focus effort as they may not apply to our Health Board or the local population or there may be other things that would take priority.

The **RESOURCES & PERFORMANCE COMMITTEE** approved delegated authority to the Chair and Chief Executive to formally approve the submission of the Delivery Plan 2025/26 on behalf of the NHS Borders Board.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received moderate assurance from the report.

10. Financial Planning 2025-2028

10.1 Mr Andrew Bone gave a presentation to the Committee on financial planning for 2025 to 2028. He advised that in terms of financial modelling assumptions were made based upon what was known and the cost of getting our performance back to where it needed to be. He highlighted several elements of the presentation including: the context that we operate within; reminder on brokerage and opening deficit articulates some of the issues reported regularly in the finance reports; additional resources including NRAC population adjustments; proposed financial plan 2025/26 best and worst case scenarios; investment scenarios; judgement to be made on appetite for investment and balance of risk; long term forecast – forecast outturn with scenarios to get to a breakeven position - cumulative deficit/brokerage; budget setting and savings targets and proposed approach; and IJB budget offer and budget setting model; underwritten IJB financial risk for 24/25.

10.2 Discussion focused on: different accounting scenarios and overlay across those scenarios and how to influence and change the model of care; transformational and quality driven containment measures; the IJB sits on the local government financial framework and has to treat an overspend position differently to Health Boards; tension between savings and investment; non recurring resources to underpin investments and what they would deliver; increase in workforce and not in performance and we need to understand the data in that respect; demographics in terms of pressures on the system the needs of the population and the workforce; move upstream and work with primary care and change the thresholds at which we treat people including prescribing; different delivery models; using digital methods for efficiencies; transformation in a transactional way; and being entrepreneurial about bringing money into the system.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the presentation and endorsed the broad approach as outlined.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received moderate assurance from the report.

11. Any Other Business

11.1 There was none.

12. Date and Time of Next Meeting

12.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 6 March 2025 at 9.00am via MS Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Audit & Risk Committee Minutes**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

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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 24 March 2025

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 16.12.24

Minutes of a Meeting of **Borders NHS Board Audit & Risk Committee** held on Monday, 16th December 2024 @ 1 p.m. via MS Teams.

Present: Mr J Ayling, Non Executive Director (Chair)
Mrs L Livesey, Non Executive Director

In Attendance: Mr A Bone, Director of Finance
Miss I Bishop, Board Secretary (Item 7.3)
Mrs B Everitt, Personal Assistant to Director of Finance (Minutes)
Mrs L Goodman, Head of IM&T / Digital Services (Item 6.3)
Ms S Harold, Senior Audit Manager, Audit Scotland
Mrs S Horan, Director of Nursing, Midwifery and Allied Health Professionals (Items 6.4 and 7.3)
Mrs S Harkness, Senior Finance Manager
Mrs L Huckerby, Interim Director of Acute Services (Joined at 1.25 p.m.)
Ms P Jackson, Clinical Governance Senior Manager, Grant Thornton (Item 6.4)
Mrs L Jones, Director of Quality Improvement
Mr M Lee, Assistant Manager, Grant Thornton (Attended for Internal Audit items)
Mrs E Mayne, Head of Internal Audit, Grant Thornton (Left at 3 p.m.)
Mrs S Swan, Deputy Director of Finance (Head of Finance)

1. Introduction, Apologies and Welcome

James Ayling welcomed those present to the meeting.

Apologies were received from Mrs L O'Leary, Non Executive Director, Cllr D Parker, Non Executive Director, Mr P Moore, Chief Executive, Mr J Boyd, Audit Director, Audit Scotland and Mrs K Hamilton, Chair.

James confirmed that today's meeting was quorate.

2. Declaration of Interest

There were no declarations of interest.

3. Minutes of Previous Meeting – 23rd September 2024

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker

The Committee noted the action tracker and that actions had been completed.

5. **Risk Management**

5.1 *In Phase Update*

Laura Jones provided an update on the implementation of InPhase, the new digital system for risk and adverse event reporting. It was noted that NHS Borders were one of the first Boards to move over to the new system and some issues had been encountered during the implementation stage so the anticipated go live date of mid December had been deferred to the 13th January 2025. Laura highlighted the huge amount of work involved for the Risk Team but confirmed they were on track to achieve this timescale. Laura added that user acceptance testing on the live system had taken place over the last week and a half which had resulted in a positive outcome.

Lynne Livesey enquired if there were likely to be any issues in supporting staff and training them due to the small size of the Risk Team. Laura confirmed that the majority of the training would be undertaken in house and that the Risk Team would be able to cope with this. Laura went on to provide an update on the company who had recently bought over InPhase and explained that the system was functioning well across other parts of the UK and that it had just required some configuration to adapt to the NHS Scotland system.

James Ayling enquired about value for money and if there was an indication of any cost savings going forward. Laura confirmed that there would be an immediate saving, although not huge, as well as ongoing savings.

Risk Review/Very High Risks

James also referred to the table circulated with the pack which provided a summary of the risks outwith their review date and asked for an update on these. Laura highlighted the Business Units who had a higher percentage of these and explained that the Risk Manager sends out reminders to managers on a monthly basis and that she would also be raising with the Boad Executive Team. It was noted that although there would be ongoing focus it was unlikely that this would be completely resolved.

As there was no detailed information scheduled to be presented at today's meeting James enquired if there were any immediate concerns which the Committee needed to be made aware of in regard to very high risks. Laura confirmed that all very high risks go through the Operational Planning Group (OPG) for review and assured that there was a robust system in place. It was further noted that Clinical Boards also bring an assurance report on their high risks to OPG to discuss if any required to be escalated by exception. June Smyth added that it is part of OPG's annual timetable to receive regular updates as well as updates on very high risks from the Clinical Boards/Business Units. June went on to provide an update on risks which the organisation are unable to tolerate and which had come forward to the Board as part of the processes in place.

The Committee confirmed it had received moderate level of assurance from the report/update.

The Committee noted the update.

6. **Internal Audit**

6.1 *Internal Audit Plan Update Report*
Emily Mayne spoke to this report which provided a summary on delivery of the 2024/25 Internal Audit plan. Emily confirmed that good progress had been made with 3 final reports being presented at today's meeting. It was noted that since the report had been issued the Governance/Risk Management audit had been scoped and would commence early in the new year. It was further noted that the productivity audit had yet to be confirmed.

Emily went on to explain that not all the days allocated to the Property Transactions audit had been utilised and it had been agreed with the Director of Finance to use these surplus days to review the outstanding recommendations and update as appropriate to allow for a smoother transition to the new Internal Auditor.

James Ayling asked for update on the productivity audit. Andrew Bone confirmed that he hoped to confirm this in the coming days once the Director who would be responsible returned from annual leave.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the report.

6.2 *Internal Audit Report – Payroll*
Emily Mayne introduced this report which had an overall rating of moderate assurance. The finding ratings were noted as 2 medium, 4 low and 1 improvement.

Emily referred to the medium rated recommendations which noted there was inefficient notification mechanisms leading to delays in updating HR and Payroll systems resulting in overpayments/underpayments. Emily explained that the key weaknesses identified were also seen regularly within other organisations so were not a particular failing for NHS Borders, however there would be an impact on the Board's financial position in regard to overpayments so this would need to be acted upon as a matter of urgency.

Lynne Livesey assumed that staff who receive an overpayment in error and don't highlight this would be taken through the normal fraud process. Andrew Bone advised that there would need to be criminal intent to involve either Counter Fraud Services or the police rather than just not making the Payroll Department aware of an overpayment of salary. Andrew assured that when errors are made the organisation look to learn from these to avoid any reoccurrence.

James Ayling referred to finding 4, namely insufficient or inappropriate application of the Pay Policy due to consideration not being given to the controls impacting

on relevant pay and conditions and noted that the Terms of Reference for the Policy and Conditions of Employment Group had not been reviewed since 2018 and enquired if the system was working as effectively as it should be. Emily felt that as this was the only governance point raised it suggested that nothing else had been picked up.

James asked for an indication on the level of overpayment recorded. Susan Swan advised that this is picked up as part of External Audit's annual audit and agreed to circulate this information around the Committee.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the report.

6.3 *Internal Audit Report – Digital*

Matt Lee introduced this report which had an overall rating of moderate assurance. The finding ratings were noted as 3 medium and 2 low. Matt advised that the audit had looked at the incident management reporting desk and noted that there were some good operational practices in place. Matt advised that there were on average 450 incidents processed every month and areas had been identified for improvement. Matt went on to explain that the findings could be split into 2 main areas, namely refining policies going forward and although there is already a distinction between problem management and incident management, operationally this had not been introduced. Matt confirmed that this had been acknowledged during the review.

Matt also advised that within the documentation reviewed there was a lot of interchange in the language used between critical and major incidences and it was felt this needed to be clarified as these covered two very different types of incidents which require different responses, i.e. a major incident would affect the whole organisation and a critical incident would affect a local area.

It was noted that the other area identified for improvement was in regard to formal reporting. Matt advised that some scorecards had been introduced but there did not appear to be any evidence of a reporting framework. There also did not appear to be follow up on recommendations arising from post incident reviews which had taken place.

Lynne Livesey enquired if there was any evidence of an incorrect response being given to an incident due to the differing classifications (critical and major) or if it was just a language issue. Matt confirmed that from the evidence looked at there had not been and incidents had been effectively managed.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the report.

6.4 *Internal Audit Report – Healthcare Associated Infections*

Pippa Jackson introduced this report which had an overall rating of partial assurance with improvement required. The finding ratings were noted as 4 medium, 2 low and 1 improvement. Pippa went on to take the Committee through the medium recommendations identified in regard to a variance in tools being used to monitor compliance with infection control in ward environments. Pippa advised that in some areas there was limited completion of these tools. A lack of local ownership of infection control oversight was also identified in some areas. Pippa went on to provide feedback from the findings.

Pippa also highlighted the lower compliance in hand hygiene, including compliance with medical staff. Pippa advised that this was not unique to NHS Borders.

Lynne Livesey advised that she was a member of the Clinical Governance Committee and confirmed that they were aware of the issues around hand hygiene compliance. Lynne was surprised to learn about the scale of the issue and the lack of awareness on processes in place and was keen to hear about the proposals to reduce and mitigate the risks.

Sam Whiting noted his thanks for the report which was very helpful. Sam advised that infection control comes under COSHH which meant there was clear contractual requirements for staff and the report provided an opportunity to remind managers of their obligations.

Lynne enquired why the processes in place for medical staff were not working. Sarah Horan advised that there are ongoing frustrations and reminded that hand hygiene is everyone's business and should not to be viewed as Infection Control's problem. Sarah advised that they would be looking to feed information into the Clinical Management Teams for each service so they can then take ownership for their areas. Sarah added that the Medical Director and Associate Medical Directors were very proactive in putting out this message. Sarah gave assurance that the team are working to implement the recommendations arising from the audit.

James Ayling noted previous reports had not been shared with staff and asked for assurance that the actions identified would resolve this. Sam confirmed that he would be meeting with Senior Charge Nurses in the new year to share the audit report and findings.

James noted that the audit had only looked at the BGH and recalled from a recent infection control report that the compliance rate for hand washing was higher in the community. Sam explained that the reason for the focus of the audit being on BGH was due to there being more concern in terms of the practice within the acute hospital environment and also the infection risk for patients in the BGH was higher than in the community due to patients being more vulnerable due to requiring more invasive treatment.

James also noted from the report that it stated the Clinical Governance Committee met on a monthly basis as he did not think this was correct. Laura confirmed that they actually meet bi-monthly, however advised that the Clinical Governance Groups of the Business Units did meet on a monthly basis.

James enquired if the findings were similar to those found in other organisations. Pippa confirmed that they were and that NHS Borders were in fact better placed than others she had seen.

The Committee confirmed it had received partial level of assurance from the report.

The Committee noted the report.

7. **Governance & Assurance**

7.1 *Information Governance – Mid Year Report*
Susie Thomson spoke to this item and took the Committee through the report and highlighted key points. Susie referred to the appendix which detailed the work and key projects undertaken by Information Governance over the last 6 months.

In terms of security metrics, it was noted that in comparison to this point last year these were slightly lower in terms of incidents or breaches, however NHS Borders continued to have the highest number of breaches of self-lookups on the Fair Warning system. Susie confirmed that this is included as part of the staff induction and training and that education/awareness would continue over the coming year.

In terms of Freedom of Information requests, it was noted that performance had improved and was in part due to some proactive work being undertaken in preparing information to be able to respond to the more complex types of FoIs. It was noted that the number of FoI requests has continually grown over the last few years.

Susie advised that in regard to cyber security this was another area where the organisation was challenged due to the increasing number of cyber incidents.

It was noted that the next Network and Information Security (NIS) audit was due to take place in February 2025 and that the action plan from the previous NIS audit, which was attached as an appendix, provided an update on progress. Susie hoped to see an improvement in the position following the audit in February but stressed there was still a lot of work to be undertaken to achieve this. It was further noted that the actions were not only relevant to Digital and IM&T as there was also a number of actions relating to business continuity.

In regard to records management Susie advised that there was increasing challenges due to a move to digital records which was largely due to the continuing volume of paper notes being produced with no strategy to move towards paperless and hoped that this would form part of the new clinical strategy which would feed into the digital strategy and move this forward.

Susie advised that there was also an increase in subject access requests with some having breached the 30 day deadline.

James Ayling referred to the issue with staff looking up their own records and asked if it was possible to amend the system so it was not possible to do this. Susie agreed to check if this would be possible.

The Committee confirmed it had received moderate assurance from the report.

The Committee noted the report.

7.2 *Audit Follow Up Report*
James Ayling advised that he had written to members of the Board Executive Team asking for focus to be given on the outstanding audit recommendations and had received several responses to this.

Emily Mayne spoke to this item and stressed that focus does need to be given to recommendations as some were extremely long standing and may no longer still be relevant. As mentioned earlier in the meeting it was noted that Internal Audit would be drilling down into these actions to ascertain if they still remained relevant so resources were not wasted looking at ones which were no longer required. James agreed it would be helpful to use the outstanding days referred to earlier to look at these over the next quarter.

The Committee confirmed it had received moderate assurance from the update.

The Committee noted the report.

7.3 *Audit Follow Up Process*
Outstanding Internal Audit Recommendations
Iris Bishop spoke to this item and advised that she and the Deputy Director of Finance had met with Internal Audit and agreed a way forward to try and resolve the issue around the amount of outstanding recommendations. It was noted that a further meeting would be taking place in the new year and a paper with the outcome and recommendations would be presented to the next meeting in March.

The Committee confirmed it had received moderate assurance from the update.

The Committee noted the report.

IM&T
Andrew Bone referred to the email supplied by the Director of Planning & Performance to the Chair of the Committee which provided an update on the outstanding recommendations. James Ayling agreed to circulate a copy around the Committee for information.

Use of Bank & Agency
Sarah Horan provided an update on the recommendations where it was noted that it was hoped the SLA would be finalised prior to the festive break. It was further noted that eRostering was progressing as per the implementation plan. Sarah advised that NHS Borders and NHS Lothian were working with RLDatix on the national bank payroll file to allow monitoring of bank workers to ensure compliance with working time regulations. It was hoped that this would be completed by end February 2025 and by the start of summer 2025 key reports would be able to be run. It was noted that the key dates had been stipulated by

RLDatix and it was not possible to amend these. Sarah confirmed that once these are in place all actions would be complete.

James Ayling enquired about an honorary contract and what was meant by this. Andrew Bone explained that this gave a person the status of an employee without being contracted from a pay perspective, i.e. allowing them to have an identity on the system but not necessarily being paid directly by NHS Borders as an employer.

The Committee noted the update.

Contract Management Arrangements
Susan Swan provided an update on the recommendations where it was noted that the preliminary work has been undertaken and work is ongoing with individual departments. Work is also taking place internally around compliance and training. It was noted that Estates and IM&T have the largest value and more complex contract arrangements in place.

The Committee noted the update.

7.4 *Debtors Write Off Report*
Susan Swan spoke to this item which provided an update on debt follow up where it was noted that £330k was being followed up as part of the Board's internal credit control processes as at end November 2024. Susan reminded of the action from the last meeting for aged debt with potential of write off to be included within the report and highlighted that this was now included.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the report.

7.5 *NHS Scotland Support & Intervention Framework Self Assessment Update*
Andrew Bone spoke to this item and reminded that a draft had been circulated for comment prior to submission and that the paper presented provided a copy of the final submission with the changes highlighted for ease of reference. Andrew advised that a formal response is awaited from Scottish Government, however feedback had been received that NHS Borders would remain on stage 3 of the escalation framework and this would continue to be reviewed. Andrew did not expect there to be much change to the next iteration but would share with members in January for comment.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the report.

8. External Audit

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

Andrew referred to the "NHS in Scotland 2024" report which was listed as for information in error and would in fact be presented to the next meeting for review and to understand if any of the actions for Health Boards would be relevant for NHS Borders.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the report.

9. **Fraud & Payment Verification**

9.1 *Countering Fraud Operational Group Update*
Susan Swan spoke to this item which detailed the activity taken forward by the Countering Fraud Operational Group (CFOG). Susan advised that the November meeting had been used for a Fraud Risk Assessment session led by CFS. It was noted that the presentation given was attached as an appendix for information.

James Ayling advised that he had attended a recent webinar which touched on why fraud is committed which was in part due to an insufficient segregation of duties. Susan confirmed that this had also been covered within a recent Technical Bulletin received from Audit Scotland and gave assurance that although it is small teams within Finance and Procurement there was a very good segregation of duties.

James enquired how staff would know who to contact if they suspected fraud. Susan explained that CFOG members, which includes a wide representation across the organisation, are asked to cascade relevant information within their teams.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the report.

9.2 *NFI Update*
Susan Swan spoke to this item which was a standard exercise undertaken by public sector bodies across the UK. It was noted that there had been no change since the last report presented other than datasets had been submitted and matches were expected on 20th December 2024. Susan advised that the levels of risk would be looked at prior to the festive break and investigations would commence in the new year.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the update.

9.3 *Fraud Allegations*
Susan Swan reported that there were currently 4 allegations of fraud and it was noted that 3 were the same as that reported at the last meeting with a further one

being concluded which was in support of a fraud allegation from another organisation.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the update.

10. **Integration Joint Board**

James Ayling noted that the IJB audit report 2023/24, subject to the final set of annual accounts, was proposing an unqualified opinion. Stephanie Harold went on to provide an update where it was noted that the final report and accounts would go forward to the IJB meeting in January 2025 for approval.

James asked for clarification on the Committee's role and what it was trying to achieve with the IJB regarding audit and accounts as he did not wish to overstep what was required.

Andrew Bone advised that the inclusion of the link to the agenda and papers was for members' information and that it was the Committee's role to ensure that the processes set out in the Scheme of Integration, in terms of the interaction between the Board and the IJB, are appropriate and to ensure that the Health Board had met its obligations and the IJB had followed up appropriately. Andrew felt that it would also be beneficial for the Committee, on behalf of the Board, to be assured that the IJB budget setting process was an effective process. There was also a need to ensure that at the point of when the IJB sets its budgets and issues directions that the directions are enacted in the appropriate manner in line with guidance and being followed up appropriately.

In regard to the budget setting process with the IJB it was noted that this would come forward to the Resources & Performance Committee as part of the wider financial plan for NHS Borders so Committee members would have the opportunity to scrutinise and challenge at that point and make a judgement if anything required to be discussed further by the Audit & Risk Committee.

Lynne Livesey enquired if there was appropriate oversight around the annual accounts process for the IJB. Andrew explained that if this was relevant to the IJB then it would not be for the Committee to have any oversight and went on to advise that challenges with the annual accounts in recent years had been related to the lack of a Chief Financial Officer. Andrew assured that a lot of work has been undertaken and it was not anticipated to see these same issues going forward.

The Committee confirmed it had received moderate level of assurance from the report.

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

10.1 *IJB Directions Tracker*

This item was deferred to the next meeting.

11. **Items for Noting**

11.1 *Information Governance Committee Minutes: 6th June 2024 (Draft)*

The Committee confirmed it had received moderate level of assurance from the minutes.

The Committee noted the minutes.

12. **Any Other Competent Business**

12.1 *Internal Audit Tender Process Update*
Emily Mayne left the meeting for this item
Andrew Bone provided an update on the tender process for the new Internal Audit contract where it was noted that a tender for the service had been issued jointly with NHS Lothian. The Director of Finance and Chair of the Audit & Risk Committee were expected to take part of the next part of the process.

13. **Date of Next Meeting**

Monday, 24th March 2024 @ 1 p.m. via MS Teams.

BE
10.01.25

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
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 3 February 2025

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 07.10.24
- Appendix No 2, Endowment Fund Board of Trustees minutes 25.11.24

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 7th October 2024 @ 2 p.m. via Microsoft Teams.

Present:
Mr J Ayling, Trustee
Mr A Bone, Trustee
Mrs K Hamilton, Trustee (Chair)
Mrs L Livesey, Trustee
Mr P Moore, Trustee (Left at 4 p.m.)
Dr L McCallum, Trustee (Left at 3.45 p.m.)
Mrs L O'Leary, Trustee
Cllr D Parker, Trustee
Mrs F Sandford, Trustee

In Attendance:
Ms C Barlow, Charity Development Manager
Ms R Egan, Fundraising Officer
Mrs B Everitt, PA to Director of Finance (Minutes)
Mrs S Harkness, Senior Finance Manager
Mr M McLean, Investment Advisor (Left meeting at 4.20 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, and in particular to Peter Moore as this was his first meeting of the Board of Trustees.

Apologies had been received from Mrs H Campbell, Trustee, Mrs S Horan, Trustee, Mr J McLaren, Trustee and Dr S Bhatti, Trustee.

2. **Declaration of Interests**

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

3. **Minutes of Previous Meeting : 17th June 2024**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker

The action tracker was noted.

5. **Endowment Advisory Group**

5.1 *Minutes of Meeting: 19th August 2024 (Draft)*
James Ayling spoke to this item and advised that the minutes were still in draft and had yet to be approved. James referred to the decision not to proceed with the funding for the new resuscitation trolleys and clarified that the question he had

asked was whether the existing trolleys were compliant with all necessary regulations so the minutes would require to be amended to reflect this.

The Board of Trustees noted the draft minutes.

5.2 *Endowment Advisory Group Report of Applications and Grants Awarded*
James Ayling spoke to this item and took Trustees through the successful and unsuccessful applications which had been reviewed by the Endowment Advisory Group at its meeting on 19th August 2024 and provided an update on each of these.

Karen Hamilton asked for any comments on the decisions made by the Endowment Advisory Group. None were raised.

The Board of Trustees noted the report.

6. Strategy & Fundraising

6.1 *Charity Plan 2024/25 – Progress Update*
Karen Wilson spoke to this item which provided a progress update on the 2024/25 Charity Plan. Karen highlighted that progress updates had been included against each of the objectives.

It was noted that 80% of donations received were made to palliative care and cancer care funds.

Karen went on to highlight the fundraising events which had been undertaken by staff groups and communities. It was also noted that the first batch of emergency toiletry bags funded by The Difference had been delivered to the Borders General Hospital for patients who are admitted unexpectedly.

Karen advised that the 3rd December 2024 had been earmarked for the Tree of Light switch on and was delighted to report that the tree this year will be donated by the supplier.

In regard to the Beacon CRM system, it was noted that focus has been on the application process and this was currently being finalised and would be captured within the standard operating procedure. Automatic claiming of gift aid was also being explored and once the new process has been confirmed with Finance this would be more efficient.

Karen referred to the recruitment of the Band 7 post within Finance, funding previously agreed by Trustees, where it was noted that the recruitment is currently on hold pending conclusion of the Finance Department service review.

Karen confirmed that there had been good progress in encouraging spend within the ‘top ten’ funds and noted that there were applications to utilise palliative care funds later on the agenda. Work was also ongoing around closing dormant funds as well as streamlining funds and making sure that the most appropriate person was named as the fund manager.

Karen Hamilton referred to the toiletry bags and asked if there had been any linkage with the forensic examination suite. Karen W confirmed that they had received other toiletries donated to the charity and she would be making contact to check if more were required.

Karen H also asked about the timeline for the Finance Department service review. Susan Swan confirmed that they were due to report on phase 1 to the Quality & Sustainability Board by December 2024 which in turn would enable a decision to be made on the post referred to earlier.

The Board of Trustees noted the update.

6.2 *Unrestricted Income Generation Strategy*

Karen Wilson spoke to this item and explained that in recognition of the success with the increased spending of funds the proposed strategy would maximise unrestricted income to the charity as well as using other approaches to generate more income. Karen highlighted that this overlapped with the charity plan and explained that this was deliberate and not an oversight. Karen felt that it was important to lay out the theory and structure for more proactive fundraising events going forward and two items were key to this, namely the charity brand where it was felt the current brand was less successful when looking to target unrestricted donations and approval was sought to develop a proposal for a costed re-brand exercise. The other was in relation to the fund structure which was currently set in a traditional format in regard to the treatment of donations. Karen explained that she would like to look at an alternative structure and stressed the importance of having classification around restricted and unrestricted donations to allow flexibility and maximise unrestricted income.

Karen also referred to the proposal to develop a Staff Ambassador Programme for the charity to help raise awareness. Although any member of staff could be an Ambassador it was proposed having a more targeted approach in the first instance and focus on staff who have been funded by The Difference to help with the initial uptake which would include a 45 minute training session on the charity.

Karen went on to highlight the section on developing an NHS Borders Charity & Fundraising Policy which the charity would work with Borders NHS Board to develop. Karen explained that such a policy was used within NHS Lothian which she had reviewed and it was noted that this would provide clarity and guidance around fundraising as well as raising awareness across the organisation.

Karen Hamilton referred to the proposal to create a new brand for the charity and noted that the current brand was around 15 years old and although it had suited at the time it was created, appreciated that things have since evolved and the charity is now looking for people to donate in an unrestricted way.

Fiona Sandford felt that it would be beneficial to look at what other Boards have in place suggesting donations be made in an unrestricted way but highlighted the importance of the language used which should be kept as simple as possible.

James Ayling noted that it was a very small proportion of unrestricted income raised over the last five months and stressed the need to increase this going forward.

Karen explained that the new CRM allowed two options to be given, namely to specify the area one wished to donate to or to donate generally to the charity which is what goes into the general unrestricted fund. It was noted that since this had been in place there had been a very high level of donations made, these were just at a lower value level and those which come with a specific wish attached were of a much higher value.

Karen Hamilton enquired if there were any OSCR requirements within the proposals outlined which would require consideration and if the work required would be manageable within the current team. Karen W confirmed that there were no OSCR requirements and that she would like to look at an overarching wider strategy with Trustees which would include timescales and in turn address resource requirements for the workload involved.

Andrew Bone referred to the comment made that larger donations tended to be targeted to a specific area and suggested that through the work undertaken on the overarching strategy there may be an opportunity to try and steer donations, even on a restricted basis, to align with the Board's strategic objectives.

Peter Moore noted the importance of the brand providing clarity around what it was tied to. Peter enquired if any mechanisms could be put in place to encourage those making donations to automatically give a standard split donation, i.e. half being unrestricted and half to a preferred fund, to allow for a better balance to be given to areas which are not as well supported.

Lynne Livesey noted her support as this would hopefully see an increase in the value of unrestricted donations received. In regard to legacies Lynne suggested communication with local solicitors etc if this did not already take place to ensure they are aware of the options.

Karen W highlighted that funding themes were included within the paper which would give people options rather than donating to a particular ward etc. Karen confirmed that legacies are received, the vast majority of which are funeral donations or in memory donations, and that the team work closely with funeral directors but appreciated more work was required to ensure they are aware of all the options available.

The Board of Trustees approved creation of unrestricted designated funds for allocation of unrestricted donations.

The Board of Trustees approved development of a Staff Ambassador Programme.

The Board of Trustees approved engagement with NHS Borders on the development of a Charity & Fundraising Policy.

The Board of Trustees approved development of a proposal for a costed re-brand exercise.

6.3 *Innovation Development*

Colleen Barlow advised that two meetings had taken place with a small group of Trustees and provided an update from these.

Colleen advised that she had a meeting arranged with the Director of Pharmacy to discuss an application for polypharmacy and frailty. A meeting was also due to take place with the Director of Quality and Improvement, who is also the chair of the Innovation Steering Group, to see how the charity can align its calls for innovative projects using that group as a pipeline.

Work would also be taking place to target restricted funds where there are existing and prioritising innovative applications and may take the shape of a roadshow going out to key stakeholders.

Karen Hamilton asked for an update on the work being undertaken to be provided at the meeting in May 2025.

The Board of Trustees noted the update.

6.4 *Charity Staffing Update*

Colleen Barlow left the meeting for this item

Karen Wilson spoke to this item advised that the current Charity Development Manager was on a two year fixed contract which would run out on 30th April 2025. Karen went on to describe the work undertaken/achievements made by the postholder to date. It was noted that the team had tried to pick up this work previously and had found it incredibly hard to do within the resources available. The request being made to Trustees was to approve funding for a permanent Band 6 Grant and Fund Engagement Manager, subject to approval following the vacancy control process. This role would also provide support to Fund Managers as well as assisting the Finance team and taking on some of their workload.

The Trustees discussed the proposal and concern was raised around whether or not this post would provide value for money, the lack of measurable outcomes detailed within the report and the significant ongoing expense this would be to the charity if approved. Trustees did not feel they were able to make a decision at today's meeting and as the contract for the current postholder was until 30th April 2025 felt that there was sufficient time to pull together further information to address the concerns noted.

Due to the timing of the next meeting Karen felt it would be necessary to hold an extraordinary meeting prior to the festive break. This was agreed.

Susan Swan also suggested that a small group of Trustees assist with the measurable objectives review for this post along with the Fundraising Manager and herself. This was agreed.

The Board of Trustees agreed to hold an extraordinary meeting to discuss this further.

7. **Financial Report**

7.1 *Financial Report and Statements to 31st August 2024*
Susan Swan spoke to this item which provided an update on the level of spend to 31st August 2024 against the level of income that had been received. Susan referred to the apportionment of investment income, management fees and gains and losses section of the report which stated the balance to the end of August on the designated fund 'in year investment movement' was £470k, however it was noted that a reduction to this balance had been made in September due to a cash transfer to cover spend commitments, therefore the actual balance at the end of September was £270k. Susan referred to discussion at the previous meeting where she had intimated that she may ask Trustees to approve apportionment of the designated fund across unrestricted and restricted funds at today's meeting, however due to the reduction in value she did not recommend doing this at the present time and would keep this under review and bring back to Trustees for approval when appropriate.

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 £5,000 received to 31st August 2024. Susan highlighted that two legacies were yet to be received.

The Board of Trustees noted the report.

8. **Funds Management**

8.1 *Investment Advisor Report*
Mark McLean spoke to this item and referred to the bullet point summary and advised that at 31st August 2024 the portfolio value was just over £5.263m. It was noted that the portfolio had generated a yield of 3.38% which equated to an annual income of around £177,891.

Mark highlighted the 1, 3 and 5 years' performance figures detailed within the summary report which he appreciated was disappointing and had been discussed previously at meetings.

Mark went on to explain that the performance gap was beginning to close in on the benchmark. Mark also referred to the activity within the portfolio over the last year and explained that there had been more than usual and this was primarily due to additional cash being invested and then divested back out.

Mark felt that the portfolio was now in a reasonable shape to benefit from some of the interest cuts as seen recently. It was noted that Government stocks had been added over the last 6 months as a safety net. Mark noted there had been a general election since the last meeting and referred to the situation in the middle east which was escalating and was being kept under constant review.

In looking forward to the next few months James Ayling enquired if anything could be done to hedge risks. Mark explained that the most drastic action would be to

move out of equities but he did not feel that the portfolio was at the stage where this course of action was necessary. It was noted that if there was a move out of equities, in relation to the situation in the middle east, this would be to cash or fixed income investments and if required could be actioned swiftly.

Fiona Sandford was pleased to see the portfolio was catching up with the benchmark and suggested benchmarking against a passive action tracker. Fiona also asked if permission was required prior to a move from equities. Mark confirmed that he would be able to benchmark against whatever Trustees wished. He also advised that he could act without prior permission of the Trustees in extenuating circumstances. Karen Hamilton was content to leave this to the Investment Advisor's discretion and asked Trustees if anyone had a differing view. No issues were raised.

The Board of Trustees noted the report.

9. **<u>Governance Framework</u>**

9.1 *Palliative Care Fund Applications*

Lynn McCallum introduced this item and provided Trustees with a presentation on the work to date which had been undertaken by the palliative care workstreams as background to the applications being put forward for a number of posts to be funded from the Palliative Care Fund.

Fiona Sandford noted her support in prioritising this and asked if the applications had been fully costed and included on costs. Fiona also recalled from previous discussions that hospice care was generally funded across Scotland using charitable funds and that NHS Borders was in the minority by having the majority of this funded by core funding.

Andrew Bone confirmed that the costings presented only included direct costs and were not full economic costs.

Karen Hamilton also noted her support for the proposals being put forward.

Lynn went on to explain that this had initially formed as part of the Financial Improvement Programme and reminded that there is not a hospice facility within the Borders as the Margaret Kerr Unit is an in patient palliative care unit. Lynne advised that there was potential for savings by beds being closed as a consequence of getting more people home, reducing the length of stay and hopefully deterring admissions in the first place.

James Ayling enquired if due to the nature of the outgoings there would be a need to rebalance the portfolio for capital and income growth as Trustees may need to give this consideration. Susan Swan advised that she would be able to work with the Investment Advisor on the level of disinvestment and spend profile when timings were clearer. It was noted that this would also have an impact on the investment income.

Peter Moore felt that it was imperative that this be taken forward as there is a drive for people to be able to die in their place of choice and this was not actively

supported in Borders. Peter stressed that this was not about cost savings but providing communities with services that matter to them.

Coleen Barlow confirmed that the ask to Trustees was to approve the applications as detailed within the pack and that ideally these posts would be long term but had been put forward as fixed term in the first instance.

The Board of Trustees approved the applications for the posts.

9.2 *Staff Lottery Proposal*

Karen Wilson spoke to this item and explained that the staff lottery had been operating for a number of years, however under the current constitution it gives governance arrangements to a group which no longer exists. It was noted that the Finance Department have continued to facilitate the staff lottery and that the only instructions for the money generated based on the current constitution is for this to be used for the benefit of staff.

Karen advised that the suggestions being put forward were to use these funds to pay for next year's staff awards event should this go ahead and create a Supporting Staff Grants Programme which would also protect some of the other funds for applications of this nature.

Karen highlighted the proposals for a relaunch which included a new constitution and would see all income generated being completely unrestricted. It was noted that at least 50% would be used as prize money for staff which would retain its original purpose of being a staff lottery.

Karen Hamilton recalled previously that this would be managed by the Staff Wellbeing Group and enquired if they had been consulted on the potential change. Karen W advised that that they had not been due to the timing of the meeting and that she planned to attend the next one to do this. Karen H stressed the need for this to be shared with the group in the interests of openness and transparency.

Andrew Bone enquired if there was a pressing need to make a decision at today's meeting or if this could be deferred. Karen W confirmed that a decision did not have to be made today. Andrew added that he was aware that the new Chief Executive was keen to produce a Wellbeing Strategy and felt that this would be a potential source and suggested deferring until more work has been progressed.

Following discussion Trustees agreed to approve the recommendations put forward within the paper.

The Board of Trustees approved the use of Fund 54 to fund the 2025 staff awards event with remaining funds allocated to a "Supporting Staff" Grants Programme.

The Board of Trustees approved the re-launch of the staff lottery under the proposed new constitution.

10. **Capital Spend**

10.1 *Adult Changing Facility Update*

Andrew Bone provided an update where it was noted that earlier in the year it had been agreed to progress with this facility under an existing contract. Due to expected costs doubling it was noted that this would now have to go out to tender and an update would be provided in due course.

The Board of Trustees noted the update.

10.2 *Macmillan Centre Update*

Karen Wilson provided an update where it was noted that work has been ongoing and they are now in the final phase. It was hoped to conclude this in the next two weeks and the service would then start moving back in. It was noted that a small event would be arranged to acknowledge the donors.

The Board of Trustees noted the update.

11. **Any Other Business**

11.1 *Investment Advisor Tender Exercise Update*

Mark McLean left the meeting for this item

Susan Swan spoke to this item. Susan referred to the discussion at the previous meeting and hoped the documentation presented gave assurance that a robust tendering exercise would be undertaken. Susan advised that she had discussed with the Director of Finance and proposed approaching the Endowment Fund Manager at NHS Lothian who would be able to offer advice. Karen Hamilton agreed that this would be a great asset.

James Ayling enquired how it would be determined who was approached to submit a tender. Susan explained that this will be advertised through a public sector portal allowing anyone to submit a tender. Andrew Bone clarified that the role of NHS Lothian's Endowment Fund Manager would be to seek independent advice as they have been through numerous tender exercises.

David Parker stated that he would expect this to be a two stage process, namely to get expert advice on who could run the tender process based on the advice from Trustees on their requirements and then to take out to tender providing expert advice in narrowing down who should be interviewed. David appreciated that there would be a cost involved which would be based on the size of the fund.

David stressed that best practice for a charitable fund would be to use someone who is properly qualified to provide this advice.

James agreed with the points made and highlighted that regardless of the size of the fund the same rules and regulations applied.

Fiona Sandford also noted her agreement with the comments made.

Andrew Bone agreed that the points made would be taken on board and suggested a further proposal be circulated virtually between meetings. This was agreed.

The Board of Trustees agreed to receive a further proposal virtually for consideration.

Music Licence
Karen Hamilton advised that due to cost efficiencies it would no longer be possible to play music in communal areas and noted that there has been a query on whether the licence required could be funded using charitable funds. Karen reminded that an application had come forward to Trustees previously and had not been successful.

Karen Wilson felt that a proposal would require to be pulled together for discussion as this would require recurring funding. Karen W went on to provide an update where it was noted that this affects waiting areas in the BGH and health centres and the cost of the licence previously paid for by NHS Borders was £20k per annum. Karen advised that there would also be the option of looking at a like for like licence or one which expands into staff areas.

Following discussion it was agreed that a paper should be prepared providing all relevant information for discussing further.

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

Monday, 25th November 2024 @ 1.30 p.m. (Extraordinary Meeting)
Monday, 3rd February 2025 @ 2 p.m.

BE
18.10.24

Minutes of an Extraordinary Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 25th November 2024 @ 1.30 p.m. via Microsoft Teams.

Present: Mr J Ayling, Trustee
Dr S Bhatti, Trustee
Mr A Bone, Trustee
Mrs K Hamilton, Trustee (Chair)
Mrs L Livesey, Trustee
Mr J McLaren, Trustee
Dr L McCallum, Trustee
Mr P Moore, Trustee
Mrs L O'Leary, Trustee
Mrs F Sandford, Trustee

In Attendance: Mrs K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Karen Hamilton welcomed those present to the meeting.

Apologies had been received from Mrs S Swan, Deputy Director of Finance, Mrs S Horan, Trustee and Ms C Barlow, Charity Development Manager.

2. **Declaration of Interests**

There were no declarations of interests.

3. **Matters Arising**

- *Music Licence Update*
  Karen Wilson spoke to this item which had been touched upon at the previous meeting and was being brought back to provide Trustees with the relevant information as requested following the recent withdrawal of the licence by NHS Borders. Karen highlighted the enormity of the work involved to pull together a costed proposal and asked Trustees if there was enough of an appetite for this to be undertaken.

  Karen Hamilton asked for an update on the current position around music being played on premises. Karen W advised that since the licence had been withdrawn clarification had been sought as to where music licences were required. Karen explained that where music is played for 'therapeutic purposes' no licence was required. Examples of where a licence would be required were waiting areas, offices and staff rooms. It was noted that a number of GP practices have since agreed to fund the purchase of their own music licence.

  A suggestion was made as to whether waiting rooms would fall under the 'therapeutic purposes' category due to any anxiety which may be caused whilst a patient is waiting on their appointment.

  Andrew Bone re-iterated that it was clear a licence would not be required when music is being played for therapeutic purposes and that he had checked the regulations on the website of the company who organises the licencing and it was

apparent that waiting rooms, staff rooms and offices are not excluded and would require a licence therefore waiting rooms could not play music without a licence.

A suggestion was made around the hospital radio which already has a licence in place and if there was an option of them broadcasting within waiting areas.

Following discussion the consensus from Trustees was that they did not wish to pursue this any further as it was not felt to be a core function.

The Board of Trustees agreed not to pursue this as they felt that this was an issue for NHS Borders' consideration.

4. **Strategy & Fundraising**

4.1 *Grant & Fund Engagement Manager Objectives*
Karen Wilson spoke to this item and thanked the small working group for all their input. Karen noted that from discussion at the previous meeting Trustees wished to understand the value this post would bring in proportion to the investment being made and it had been agreed to look at the specific objectives in order to demonstrate this. Karen explained that the objectives focussed on the key areas of work for this post, namely fund engagement, grant making and monitoring and evaluation which had been looked at over the short, medium and longer term. Karen highlighted the shift to a more strategic way of working when looking at the longer term and noted that the current way of working was more reactive. Karen advised that the objectives detailed within the report were over and above the operational day to day activities within the job description. Karen went on to provide Trustees with an update on the work which would be undertaken against each objective.

Karen also referred to the national review which is still ongoing and has no timescales for completion. Karen advised that operationally there were processes which could be put in place and that work has been undertaken by the Charity Development Manager. Karen stressed that with this additional resource the charity would be in a much better position to take forward the recommendations from the review as and when these come forward.

Karen advised that a benchmarking exercise had also been undertaken against other like for like charities which concluded that The Difference sat within an acceptable benchmark.

Karen Hamilton enquired about the costs detailed within the paper and asked if these included on costs. Karen W advised that the costs noted were the actual costs charged against the Endowment Fund in 2023/24.

James Ayling referred to the anticipated changes within charity law which would see the range of offences for being disqualified as a Trustee being extended to staff and volunteers who have a senior management role within a charity and assumed that this would be taken into account as part of the employment process.

Sohail Bhatti felt that it would be helpful to include in totality the entire pathway from fundraising all the way through to expenditure as he felt there was more focus on the expenditure side. Karen H agreed that it would be helpful if the job description for the post captured this element. Karen W appreciated that this could have been illustrated better but reassured that the existing Charity Development Manager had already made a number of changes within the fundraising approach due to having a better understanding of the expenditure. Karen W added that the team already work together closely and by having the permanency of this post it would embed the whole team approach further.

The Board of Trustees noted the objectives of the role and approved the funding for a permanent Band 6 Grant & Fund Engagement Manager to be recruited to, subject to approval from local vacancy control mechanisms.

5. **Any Other Business**

James Ayling asked for an update on the tender process for the Investment Advisor. Andrew Bone agreed to arrange for a virtual update to be circulated to Trustees.

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

Monday, 3rd February 2025 @ 2 p.m.

BE
11.12.24

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3rd April 2025**
Title:	**Finance Report – February 2025**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Senior Finance Manager** **Janice Cockburn, Finance Business Partner** **Paul McMenamin, Finance Business Partner**

1 Purpose

This is presented to the Committee for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Effective

2 Report summary

2.1 Situation

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 impacts in relation to Climate Change within 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, 18th March 2025
- Board Executive Team, 25th March 2025

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 the end February 2025

FINANCE REPORT FOR THE PERIOD TO THE END OF FEBRUARY 2025

1 Purpose of Report

1.1 The purpose of the report is to provide committee members with an update in respect of the board's financial performance (revenue) for the period to end of February 2025.

2 Recommendations

2.1 Committee Members are asked to:

2.1.1 **Note** the contents of the report including the following:

YTD Performance	£13.45m overspend
Outturn Forecast *at current run rate*[1]	£14.67m overspend
M11 Review Forecast (adjusted trend)	£18.00m overspend
Projected Variance against Plan (M11 Forecast)	£7.76m improvement
Actual Savings Delivery (current year effect)	£8.43m (actioned)
Projected gap *to SG brokerage*	£3.20m (M11)

2.1.2 **Note** the assumptions made in relation to Scottish Government allocations and other resources.

3 Key Indicators

3.1 Table 1 summarises the key financial targets and performance indicators for the year-to-date performance to end February 2025.

Table 1 – Key Financial Indicators

	Financial Plan £m	Month 11 £m
Summary		
Year to Date (forecast/actual)	(23.61)	(13.45)
Core Operational	(12.30)	5.48
Savings	(13.46)	(19.16)
Average Monthly Run Rate	(2.15)	(1.22)
Outturn Forecast – trend (pro-rata)	(25.76)	(14.67)
Updated Forecast – M11 Review	-	(18.00)
Recurring Savings		
Full Target	(28.11)	(28.11)
In year target	*(11.24)*	*(11.24)*
Forecast Delivery	14.64	11.24
Schemes Implemented	-	7.40
Planned/Mandated Schemes	7.93	0.07
Cost Avoidance Measures	2.00	*2.00*
Non Recurring Savings	-	1.03
Scot Gov Support		
Brokerage Cap	14.80	14.80
Forecast Overspend after brokerage (M11)	(10.96)	(3.20)
Accumulated Brokerage Mar-24	35.53	35.53

[1] Current run rate is included to provide comparator to forecast; where there is significant variation between run rate and forecast this may indicate a requirement for additional management action in order to achieve the forecast. In current forecast (M11) the position illustrates the expected additional expenditure to be incurred in March which has not yet impacted on year to date.

4 Summary Financial Performance

4.1 The board's financial performance as at 28th February 2025 is an overspend of £13.45m. This position is summarised in Table 2, below.

Table 2 – Financial Performance for ten months to end February 2025

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Revenue Income	287.43	364.39	332.94	333.26	0.32
Revenue Expenditure	287.43	364.39	316.57	330.34	(13.77)
Surplus/(Deficit)	**-**	**-**	**(16.37)**	**(2.92)**	**(13.45)**

4.2 Core Operational Performance

4.2.1 The core operational performance excluding savings is £6.05m overspent. This position has been adjusted to £5.48m (underspent) in anticipation of additional resources not yet implemented within operational budgets.

4.2.2 The overall impact of these adjustments is a £11.53m improvement included within the position reported above. These adjustments are summarised as follows.

4.2.3 Anticipated release of reserves held in respect of areas such as non-pay growth, and any flexibility identified within the reserves. As part of the ongoing reviews further flexibility within the reserves was identified, and work continues to establish the basis for release of areas such as non-pay growth into the revenue budgets. The level of funding assumed to be released is £6.20m YTD. This represents an improvement to the forecast outturn position of £0.30m, to a forecast outturn of £18.00m deficit.

4.2.4 Financial flexibility in respect of balance sheet items remains at £5.27m full year, with £4.83m released YTD. This excludes further flexibility generated through non-recurrent slippage in revenue budgets.

4.3 Savings Delivery

4.3.1 As noted in Table 1 (key financial indicators), the overall financial performance at Month 11 is £13.45m overspent, of which £19.16m represents unmet savings.

4.3.2 The financial plan assumes delivery of £14.64m savings during 2024/25 which would result in a residual balance of unmet savings to be carried forward of £13.46m. Pro-rata to Month 11 this would project a shortfall of £12.34m.

4.3.3 The year to date position of £14.64m unmet reflects the savings profile of business unit plans which anticipates a greater level of delivery to be achieved within later financial periods.

4.4 Recurring savings delivered to date have a current year effect of £7.40m. This is higher than the total savings delivery in 2023/24, however, in line with previous agreement, this figure does include £1.0m retention of Waiting Times core funding following confirmation of additional Scottish government allocation which offsets expenditure in current plans.

4.5 Despite this level of savings delivery, the overall forecast savings position remains at risk and is discussed further in Section 6 of the report.

5 Financial Performance – Budget Heading Analysis

5.1 Income

5.1.1 Table 3 presents analysis of the board's income position at end February 2025.

Table 3 – Income by Category, year to date February 2024/25

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
SGHSCD Allocation	266.47	335.71	307.73	307.73	-
Family Health Services	10.24	16.30	15.45	15.45	-
External Healthcare Purchasers	4.93	4.58	4.22	4.37	0.15
Other Income	5.79	7.80	5.54	5.71	0.17
Total Income	**287.43**	**364.39**	**332.94**	**333.26**	**0.32**

5.1.2 Income in relation to external contract is slightly over recovered due to the inclusion of additional patient income from NHS Lothian Mental Health service where support was provided on a short-term basis in previous months and has continued to over recovery due to a high cost one off emergency patient from out with Borders.

5.2 Operational performance by business unit

5.2.1 Table 4 describes the financial performance by business unit at February 2025.

Table 4 – Operational performance by business unit, February 2025

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Operational Budgets Business Units					
Acute Services	80.07	88.01	80.40	81.80	(1.40)
Acute Services - Savings Target	(6.79)	(4.40)	(4.04)	-	(4.04)
TOTAL Acute Services	**73.28**	**83.61**	**76.36**	**81.80**	**(5.44)**
Set Aside Budgets	32.24	35.10	32.13	34.79	(2.66)
Set Aside Savings	(4.17)	(3.84)	(3.52)	-	(3.52)
TOTAL Set Aside Budgets	**28.07**	**31.26**	**28.61**	**34.79**	**(6.18)**
IJB Delegated Functions	109.56	161.70	138.87	140.69	(1.82)
IJB – Savings	(8.32)	(5.64)	(5.27)	-	(5.27)
TOTAL IJB Delegated	**101.24**	**156.06**	**133.60**	**140.69**	**(7.09)**
Corporate Directorates	22.38	25.34	22.96	22.14	0.82
Corporate Directorates Savings	(2.36)	(1.87)	(1.72)	-	(1.72)
TOTAL Corporate Services	**20.02**	**23.47**	**21.24**	**22.14**	**(0.90)**

	Opening Annual Budget	Revised Annual Budget	YTD Budget	YTD Actual	YTD Variance
Estates & Facilities	22.92	24.86	22.79	23.72	(0.93)
Estates & Facilities Savings	(2.26)	(2.15)	(1.98)	-	(1.98)
TOTAL Estates & Facilities	**20.66**	**22.71**	**20.81**	**23.72**	**(3.57)**
External Healthcare Providers	36.17	36.94	33.59	33.97	(0.38)
External Healthcare Savings	(4.21)	(2.76)	(2.63)	-	(2.63)
TOTAL External Healthcare	**31.96**	**34.18**	**30.96**	**33.97**	**(3.01)**
Board Wide					
Depreciation	5.87	5.87	5.38	5.38	-
Year End Adjustments	-	(11.82)	(11.92)	(12.15)	0.23
Planned expenditure not yet allocated	6.32	14.61	7.46	-	7.46
Board Flexibility	-	5.27	4.83	-	4.83
Financial Plan 25-26 Pre-Commitments	-	(0.83)	(0.76)	-	(0.76)
Total Expenditure	**287.43**	**364.49**	**316.57**	**330.34**	**(13.77)**

5.2.2 **Acute[2] Overall**.

The position is £11.62m overspent. £4.06m relates to operational overspend and £7.56m relates to non-delivery of the three year saving targets of £10.3m.

The proportion of saving anticipated in 24/25 is £3.1m recurring and good progress continues with full year recurring saving of £3.0m either retracted or ready for retraction from budget. Work is continuing to identify the remaining £0.1m of savings to retract during March to ensure to ensure that on a recurring basis the Acute Clinical Board has achieved the minimum Scottish Government savings target of 3%.

The operational overspend in the eleven month to February is £4.06m. The monthly level of overspent in February broadly similar to that experienced in the winter months and is in line with the projected out turn reported to Scottish Government in both the Quarter 2 and 3 returns.
Therefore, the ongoing expenditure trend, which will lead to a forecast year-end of £5.7m excluding savings, remains unchanged.

There has been no reduction in 22 additional beds, open across the Acute site and the bedded area known as “blue ED”, which will continue until the end of 24/25. This additional capacity requires to be staffed safely and this required 28.94wte made up of both registered and unregistered nurses. No funding has been allocated for these staff and these costs are significantly contributing to the level of overspend across Acute Clinical Board. Currently there are up to 10 additional beds which can be utilise over the winter period to deal with the normal level of additional activity experienced over winter. These additional 10 beds are in the main being staffed via agency nurses and will continue to be available until 31 March 25.

Cancer drugs continue to overspend (£1,353k) with activity increasing in the region of 8% per annum and no additional funding allocated over the 23/24 budgeted level. The level of expenditure is a major element of the year-end forecast with drugs contributing £2.6m of the £5.7m out turn overspend.

[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.

Instruments continue to contribute to the overall position in Acute (£1,077k) with theatre and diabetic services being the main areas of overspend. The overspend in diabetic services is fully understood and is in relation to the increased number of new pump allocated by SG with the recurring costs for consumable and replacement pumps now having to be picked up by the NHSB. The theatre supplies continue to overspend and the trend continue is directly related to the level of unfunded inflation within the system, which is running at more than 10% per year.

5.2.3 **Acute services** (excluding Set Aside) are reporting overspend of £5.44m including eleven months of the 10% savings requirement over 3 years. The operational element of the overspend is £2.37m on core budgets. The position has improved due to the allocation of diagnostic funding received from SG into the core position. Ward 7/9 continue to overspent related to the additional surge beds which have been open consistently during April to February and Ward 8 has been open on a number of occasions during December and February. Cancer drugs show an overspent by £1.3m due to increased activity in the SACT service. Theatre supplies continue to affect the overall position adversely. Also negatively affecting the overall position is diagnostic waiting times funding currently not allocated. The funding has recently been received and will be allocated in the next financial position report improving the currently positon. However, it should be noted that there is a non-recurring benefit to the overall position from vacancies in cancer and ITU nursing.

5.2.4 **Set Aside.** The set aside budget is overall £6.18m overspent, including eleven months of the 10% saving requirement over three years. The operational element of the overspend on core budget is £2.42m. There continues to be an overspend in relation to the additional beds in “blue ED”. Maternity leave cover in ED medical staffing continues to put pressure on the budget due to the use of a high cost agency medic and this will continue until Mid-April. In addition, 15 unfunded surge beds have remained open consistently between April and February contributing to the high level of overspend. In addition, drugs pressure continues in neurology and respiratory as no drugs uplift has been allocated for 24/25. The overspend related to the additional beds is being offset by underspend in nursing in specialist areas such as hospital at night, diabetic liaison and stroke as these vacancies are filled this underspend will no longer be available to offset the overspending areas.

5.2.5 **IJB Delegated.** Excluding non-delivery of savings, the HSCP functions delegated to the IJB are reporting a net over spend on core budgets of £1.820m. Within Mental Health, medical agency use (locums) continues to be a pressure (£0.499m at M11), offset by £0.121m in the MH Drugs budget and savings arising from a further increased number of vacancies across Mental Health Nursing pay budgets (£0.608m) and Psychology (£0.156m). Primary Care prescribing pressure has increased considerably during Q3 due to a significant and consistent increase in the volume of items prescribed October to January (£1.784m) The largest area of financial pressure relates to Learning Disability out-of-area placements at £1.720m. The remaining key pressure relates to Sexual Health Drugs (£0.105m).

5.2.6 A significant proportion of these pressures are currently offset non-recurrently by ongoing vacancies across all areas, including nursing workforce models (£0.485m), Allied Health Professionals (£0.329m), Dental services (£0.345m).

5.2.7 **Corporate Directorates** are reporting a net under spend of £0.82m on core budgets. The underspend continues as in previous months and is mainly within staffing areas in a number of departments such as the Workforce and Public Health Directorate where there are currently a number of vacant posts. Recovery of income particularly from the occupational health service is also contributing to the underspend on operational budgets.

Estates & Facilities are reporting an operational overspend of £0.93m. The overspend in Estates is related maintenance costs, service contracts and utilities. Currently only maintenance work classed as high-risk is being undertaken however this has still generated an overspend of £0.2m on the maintenance supplies budget. Service contracts are an area of concern and work is being undertaken to ensure that all contracts are appropriate and placed at the correct level for service requirement. However, the budget is currently overspent by £0.3m. Utilities continue to be an area of concern within Estates with the level of overspend being £0.6m to the end of February. These pressures are being offset by an underspend on staffing budgets in the Estates service of £0.2m. Patient travel continues to be an issue in Facilities with increased number of patients requiring to be transported to Edinburgh for cancer treatment contributing to the overspend by approximately £100k and renal transport increasing by a further £100k. A full review of how patient transport services are provided is about to commence. There are also a significant level of vacancies within both Estates and Facilities staffing budget that are also being utilised to offset overspends. There is the potential for greater recurring pressure within the Estates and Facilities budget should recruitment of all vacancies be undertaken and this should be noted as a risk.

External Healthcare Providers. Excluding savings there is an over-spend of £0.38m.The main area of overspend related to contracts with NHS Lothian for both Primary Care and ECCM (Acute) Contract. High-level patient activity is available and this is being monitored but due to the move from average cost to patient level information, costing (PLIC) being implemented the complexity of patient's is increasing costs.

6 Savings Delivery

6.1 The savings targets set within operational budgets represent 10% of the Board's overall baseline expenditure (£28.1m). These targets are expected to be delivered over a three-year period and targets set for 2024/25 are £8.43m recurring and £2.81m non-recurring.

6.2 The financial plan sets out an expected level of savings delivery in 2024/25 of £14.64m, of which £2.07m is expected to be non-recurring. The expected delivery incorporates expectation of additional savings of £3.4m to be delivered above the level of in year delegated savings targets. This includes schemes remaining in development that present a risk to delivery of the planned level of savings.

6.3 Actual Savings Delivery

Table 5 below shows actual level of savings achieved to date, representing the current year value for the 12 months to end March 2025.

Table five – Savings achieved as at February 2025

	Savings Target £m	Recurring Savings Achieved £m	Non Recurring Savings Achieved £m	Total Achieved £m	Unmet Savings (current year) £m	Unmet Savings (against 3 year target) £m
Acute Services	(2.51)	2.20	0.00	2.20	(0.31)	(4.30)
Set Aside	(1.67)	0.53	0.00	0.53	(1.14)	(3.60)
IJB Directed Services	(2.30)	1.47	0.00	1.47	(0.83)	(4.09)
Prescribing	(1.03)	1.21	0.00	1.21	0.18	(1.23)
Corporate Directorates	(1.16)	0.44	0.23	0.67	(0.49)	(1.90)
Estates & Facilities	(0.91)	0.11	0.04	0.15	(0.76)	(2.10)
External Healthcare Providers	(1.68)	1.45	0.76	2.21	0.53	(2.75)
Total	**(11.26)**	**7.40**	**1.03**	**8.43**	**(2.83)**	**(19.96)**

6.3.1 Against the 2024/25 target, £8.43m has been delivered to date. This reflects actual adjustments reported through the finance systems and impacting on service budgets and does not include any cost avoidance measures which do not result in budget retraction.

6.3.2 The balance of savings to be delivered in 2024/25 is £2.83m. Within this figure is some elements of non-recurrent savings target against which offsetting actions are in place but which are not directly reported against target. The level of unmet savings remaining against the three-year target (10%) is £20.11m.

6.4 Cost Avoidance Measures

6.4.1 A number of cost avoidance measures are in place through FIP and grip & control schemes. In general, these measures are not tracked except where there is material impact over the medium term. The largest element of these schemes is in relation to Agency cost avoidance and Table 6 outlines the year to date and average monthly trends in relation to these measures. Based on M11 year to date, the projected savings identified in the Q1 review which were £2m have now been met.

Table 6 - Agency Use by Staff Group

	Apr-Jan			Ave Monthly (FYE)		
	2023/24 £k	2024/25 £k	Movement (increase/ -decrease) £k	2023/24 £k	2024/25 £k	Movement (increase/ -decrease) £k
Medical	2,853	1,625	-1,228	267	148	-119
Nursing	861	432	-429	79	39	-40
Other	843	439	-405	74	40	-35
	4,557	**2,495**	**-2,062**	**421**	**227**	**-194**

6.5 Progress towards Implementation

6.5.1 The Project Management Office (PMO) maintains a register of all schemes which are included within agreed plans. Schemes in development do not appear within this register until such time as they are developed to Gateway 1.

6.5.2 Additional measures have been introduced for 2024/25 to ensure that performance is monitored against plan. Targets have been set for progress against each gateway, and this is reported monthly to the Financial Improvement Programme (FIP) Board. This includes escalation of individual business units to more frequent steering group meetings and implementation of local vacancy control measures where necessary.

6.5.3 Schemes which are expected to be cost avoidance (i.e. do not impact on budget but result in a reduction to overall expenditure) are not presently reported through the mandate process. Reporting of such schemes is being reviewed as noted under 'Cost avoidance measures' above.

6.5.4 Table 7 summarises the recurrent plans currently identified by business units for 2024/25 as at February 2025. This is set against the 3% recurring target.

Table 7 – Recurring Plans 2024/25 by Business Unit

	Number of Schemes	**3% Target £m**	**FYE £m**	**PYE £m**
Acute	32	(3.13)	2.94	2.58
Commissioning	10	(1.26)	1.45	1.45
Corporate	25	(0.87)	0.59	0.56
Estates	2	(0.30)	0.04	0.04
Facilities	4	(0.38)	0.13	0.07
IJB - MH/LD	21	(0.65)	0.69	0.52
IJB - PACS	29	(1.84)	1.05	0.98
Organisation Wide	36	0.00	1.34	1.22
	159	**(8.43)**	**8.23**	**7.43**

6.5.5 This position shows that there has been minimal movement between the position reported in February compared to the position reported in January (M10).

6.5.6 Services continue to review the phasing of plans not yet implemented which results in movement in plans and updates are provided to the PMO. As evidenced in Table 8, below, there has been a shift in schemes recorded at all levels.

Table 8 – Recurring Plans 2024/25: Progress by Gateway

	Last Month			**This Month**		
	FYE £m	**PYE £m**	**Total Schemes**	**FYE £m**	**PYE £m**	**Total Schemes £m**
At planning stage	-	-		-	-	
Gateway 1	0.09	0.06	3	0.09	0.06	3
Gateway 2	0.02	0.01	1	0.02	0.01	1
Gateway 3	0.12	0.11	3	-	-	-
Gateway 3 - Blue	7.98	7.25	152	8.13	7.37	155
Total Schemes	**8.21**	**7.42**	**159**	**8.23**	**7.43**	**159**

6.5.7 Table 8 describes the same information as Table 7 in terms of the progress towards implementation through the Gateway mandate process. Schemes which are reported as 'Gateway 3 Blue' are fully implemented.

6.5.8 Where there has been reduction in individual business unit plans this will be addressed through FIP steering group meetings; additional actions will be sought to secure delivery at least to the level of savings target in year.

6.5.9 It is likely that this situation will increase the reliance upon non-recurrent savings in place in 2024/25 and may therefore leave a shortfall against recurring savings thus impacting on the opening deficit at April 2025. This will be reviewed through the development of the draft financial plan.

6.5.10 As noted in paragraph 6.5.5 above, there has been minimal movement in the overall schemes, with Table 8 demonstrating that there continues to be progress towards implementation. The proportion of schemes which are now at GW3 is 99% (99% FYE).

7 Key Risks

7.1 This paper deals with the Board's in year financial performance and because of the timing of the report, which covers the period to end February 2025, there is a high degree of confidence in the position set out in the forecast presented within the paper, with limited risk of significant variation from forecast in the final month (March) of the current financial year.

7.2 One emerging risk to the forecast is the increase in projected expenditure within primary care prescribing. Given the variation identified to date it is unlikely that this presents a material risk to the in year forecast, with the main risk being the impact on growth projections set out in the Board's future financial plans. This will be considered further via the financial plan and through regular monitoring reports in 2025/26.

7.3 Financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 547). This risk was reviewed at the Resources & Performance Committee at its meeting on 6th March 2025 and is subject to further review following confirmation of the Board's financial plan for 2025/26.

7.4 Where identified, risks are currently reported on an individual basis through the InPhase Risk Management system.

Appendices

- N/A

Author(s)

Samantha Harkness Senior Finance Manager Sam.harkness@nhs.scot	Paul McMenamin Deputy Director of Finance Business Partner (IJB Services) Paul.mcmenamin@nhs.scot	Janice Cockburn Deputy Director of Finance Business Partner (Acute & Corporate Services) Janice.cockburn@nhs.scot

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3rd April 2025**
Title:	**Medium Term Financial Plan**
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 17th March 2025. 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 does not meet the requirements set out by Scottish Government[1].

[1] The Medium Term Financial Planning framework requires NHS Health Boards to present financial plans which are balanced (i.e. breakeven) over a three year planning cycle, with no greater than +/- 1% variance against budget in a single year.

Further to this, Scottish Government have indicated that there will be no brokerage available to NHS Boards in 2025/26 and this means that there remains significant uncertainty about how the residual gap identified in the plan is to be addressed.

The Board is therefore requested to approve its medium-term financial plan for the period 2025/26 to 2027/28 on a provisional basis subject to final agreement with Scottish Government.

In order to maintain effective systems of internal control, including budgetary control, it is proposed that the Board sets an initial budget for 2025/26 in line with the expenditure commitments set out in the plan. This budget may be subject to variation following confirmation of Scottish Government position with regard to the Board's financial plan.

2.2 Background

Financial Operating Environment

NHS Borders remains at Stage 3 on the Scottish Government's Support & Intervention Framework. This framework sets out the five stages at which individual Health Board performance will be assessed and how the Government will monitor and act in response to this performance. The framework is applicable across all aspects of Board performance, however NHS Borders' performance escalation status is specific to financial performance.

Figure 1 – Scottish Government Support & Intervention Framework

Stage 1 Steady state	Boards are delivering in line with agreed plans. Normal reporting arrangements in place and no additional or tailored support is required.
INFORMAL SUPPORT AND INTERVENTION	
Stage 2 Enhanced monitoring	There is some variation from agreed plan(s) and a possible delivery risk if no remedial action is taken. At this stage, a Board-led support package or recovery programme should be agreed and implemented. This is the pre-formal escalation stage and risks and/or issues should be raised, either by the Board or by the relevant SG policy lead/s; if necessary, taken to NPPOG for consideration.
FORMAL ESCALATION	
Stage 3 Enhanced monitoring and support	There is significant variation from agreed plan(s). The level of risk is likely to have increased, with performance stagnating or deteriorating below agreed levels, and the Stage 2 Recovery Plan having proved ineffective or insufficient. At this stage, an SG commissioned tailored support package is required and there will be enhanced monitoring of implementation and progress. NPPOG will be informed of progress on a regular basis.
Stage 4 Senior external support and monitoring	There are significant risks to delivery and the Recovery Plan or Tailored Support is not producing the required improvements. At this stage, senior level external support is required, and will report to an Assurance Board chaired by SG. The onus remains on the NHS Board to deliver the required improvements. The Assurance Board will report direct to the Chief Operating Officer for NHS Scotland and DG Health and Social Care. NPPOG will be informed of progress on a regular basis.
Stage 5 Statutory Intervention	At Stage 5, the level of risk and organisational dysfunction is so significant that the NHS Board requires direct intervention using statutory powers of direction.

During 2024-25 Scottish Government undertook review of Health Boards' status and it was confirmed that NHS Borders would remain at its current level of escalation. This was reflective of progress to date in relation to savings delivery, together with review of

the financial controls and governance in place within the Board. Update on this position was reviewed via the Audit & Risk Committee at its meeting in December 2025.

The budget set out by Scottish Government in December 2024 and subsequent discussions via NHS Directors of Finance meetings during the early part of 2025 have continued to highlight the significant financial constraints within which NHS Scotland is operating.

The Scottish Government have set out an initial assessment of Health Board plans for 2025-26 in which Boards are grouped within three tiers of financial performance, reflective of the scale of projected deficits.

A number of Health Boards are expected to be able to deliver a breakeven position in year, supported by additional financial sustainability funding made available via RRL (this is described further under Section 2.3, 'Assessment').

A further group of Health Boards are expected to be able to operate within 1% variance against their Revenue Resource Limit (RRL) and therefore achieve the minimum requirements for single year financial performance as set out in the Medium term financial framework.

A small number of Health Boards are identified as being unable to meet these conditions, reporting a projected deficit which exceeds 1% of RRL. NHS Borders are within this third group/tier.

The financial plan set out in Section 3 presents a position which indicates the Board will be operating at 3.6% above its RRL in 2025-26. This position is predicated on delivery of 3% recurring savings and a further 1% non-recurring savings, with further mitigation through release of financial flexibility and ongoing management of in year performance.

Given this context it is anticipated that there will continue to be a close level of financial performance monitoring during 2025-26 and that the Board's escalation status will remain under review.

Other Relevant Context

There is an increasing focus on delivering improvement in operational performance and the need to balance financial improvement against non-financial risks in relation to service improvement and performance, quality and patient safety, and clinical and other workforce sustainability. This is subject to active discussion through the NHS Scotland National Planning & Delivery Board, Board Chief Executive meetings, and through emerging frameworks for Regional collaborative working and performance support.

Within this context it is expected that delivery of financial performance improvement will be balanced against service efficiency and productivity gains contributing to reducing length of waits and reducing harm. It is also anticipated that as the pace of progress towards identifying wider whole system reform increases this will become an important contributor towards longer term transformational change and the delivery of financial reform.

This remains an areas of significant uncertainty, both in terms of how changes will be implemented and the timescales for this. As a result, the financial operating framework

is expected to evolve throughout 2025-26 and this will impact on how performance is delivered and the pace at which financial improvement can be achieved.

Draft Financial Plan

The Financial Plan has been prepared with review and input from the Resources & Performance Committee during its development. The Committee received an initial draft plan at its meeting on 16th January 2025 and a further update to this plan on 6th March 2025.

The updated plan presented to the Committee in March set out a projected deficit before savings of £31.3m in 2025/26, with expected savings and management actions reducing this deficit to a projected outturn position of £19.1m deficit in year.

The plan presented a three-year trajectory which highlighted an ongoing shortfall between expected levels of funding and projected expenditure each year. This position reflects assumptions regarding level of Scottish Government allocation, pay & price inflation, medicines horizon scanning, and general impact of population growth on demand for services.

The cumulative effect of this trajectory is that the Board's deficit before savings is expected to increase to £45m by March 2028. The plan assumes a level of 3% recurring savings to be delivered annually (cumulatively £28m over 3 years). The projected deficit after savings at March 2028 is £13.4m.

At time of preparation the draft plan highlighted that savings to the value of the target had not yet been identified and that where plans were identified these remained at an early stage towards implementation and there was a further risk of slippage against levels of savings expected to be achieved in 2025/26.

It was noted that the development of the Board's revised organisational and clinical strategy would set out objectives for service transformation and efficiency over a five year period to 2030, outlining a refreshed approach to how the organisation will address risk in relation to the safe and effective delivery of health and care, operational performance, workforce and financial sustainability.

In this context the financial plan provides a framework for how budgets will be set over the medium term, including anticipated expenditure in support of the strategy, but it is recognised that this will continue to be reviewed and adapted through the development of a financial strategy in support of the wider organisational and clinical strategies.

2.3 Assessment

Summary

A final financial plan was submitted to Scottish Government on 17th March 2025. The final plan includes additional revenue resource allocations advised by Scottish Government, including recurrent and non-recurrent funds available in 2025/26.

Table 1 summarises the projected outturn position as set out in the final medium term financial plan.

Table 1 – Summary, medium term financial plan

	2025-26			2026-27			2027-28		
	R	NR	Total	R	NR	Total	R	NR	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cumulative Gap before Savings	*(35.1)*	*7.7*	*(27.4)*	*(40.8)*	*0.4*	*(40.4)*	*(46.8)*	*0.3*	*(46.5)*
In year Gap before Savings	(35.1)	7.7	(27.4)	(31.7)	0.4	(31.3)	(28.3)	0.3	(28.0)
Savings Target	9.1	5.5	14.6	9.4	3.1	12.5	9.7	3.2	12.9
Forecast Outturn	**(26.0)**	**13.3**	**(12.8)**	**(22.3)**	**3.5**	**(18.8)**	**(18.6)**	**3.5**	**(15.1)**

The plan sets out the projected outturn position in 2025-26 and the following two years, reflective of assumptions in relation to additional resources, projected expenditure growth, and level of savings. This indicates a projected deficit, after savings, of £12.8m in 2025-26, with increase to £18.8m in 2026-27 and thereafter a reduction to £15.1m at March 2028.

As advised in previous iterations of the plan, these projections make provision of 3% for the cost of public sector pay policy and assume that any additional costs will be fully funded via additional Scottish Government allocation.

The cumulative deficit before savings is projected to rise to £46.5m by March 2028. The In-year gap before savings assumes 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 set at £28.2m (3% p.a.). The £15.1m gap at March 2028 requires that these savings are delivered in full over the 3 year term of the plan.

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

Movements in the Plan

There is an improvement of £6.3m against previous draft (2025/26). Table 2 describes changes to the 2025/26 plan from the position presented to the Resources & Performance Committee at its meeting on 6th March 2025.

Table 2 – Movements against previous version

	Draft			Final			Movement		
	R	NR	Total	R	NR	Total	R	NR	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Opening Gap	**(33.1)**	**(2.2)**	**(35.3)**	**(35.0)**	**(2.2)**	**(37.2)**	**(1.9)**	**0.0**	**(1.9)**
Additional Commitments	(19.5)	(1.1)	(20.5)	(22.6)	(1.1)	(23.7)	(3.2)	0.0	(3.2)
Additional Resources	19.1	5.5	24.6	22.5	11.0	33.5	3.4	5.5	8.9
Net Gap Before Savings	**(33.5)**	**2.2**	**(31.3)**	**(35.1)**	**7.7**	**(27.4)**	**(1.6)**	**5.5**	**3.9**
Savings	9.1	3.0	12.1	9.1	5.5	14.6	0.0	2.5	2.5
Forecast Outturn	**(24.4)**	**5.3**	**(19.1)**	**(26.0)**	**13.3**	**(12.8)**	**(1.6)**	**8.0**	**6.4**

The movements in plan are as follows:

Category	Movement	Description
Opening Gap	£1.9m	Increase of £1.9m against initial assessment, reflecting additional cost pressures noted at Q3 review and M10 financial performance in relation to Medicines & Prescribing (£1.4m) and Energy costs (£0.5m).
Additional Commitments	£3.2m	The plan has been updated to reflect assumptions regarding Employer National Insurance Contributions (ENIC) previously omitted pending confirmation of SG funding. This equates to £3.2m, inclusive of assumed impact on NHS cross boundary SLAs.
Additional Resources	£8.9m	Resources confirmed after preparation of the draft plan reviewed by the Resources & Performance committee include: ENIC funding at 60% of estimated costs - £1.9m. This figure remains provisional pending final assessment of actual costs. Funding is consistent with revenue support available to local authorities and other public sector organisations. Financial Sustainability – NRAC (population weighted) share of £70m recurring and £250m non-recurring, made available to Health Boards to provide certainty on level of financial support. NHS Borders share is estimated at £1.5m recurring and £5.5m non-recurring (£7.0m total).
Savings	£2.5m	Increase to previous assumptions regarding non-recurrent flexibility to be realised in 2025/26. This will be achieved through review of in year provisions, slippage on allocations and release of flexibility from Board and IJB reserves.

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

	2025-26			2026-27			2027-28		
	R £m	NR £m	Total £m	R £m	NR £m	Total £m	R £m	NR £m	Total £m
Planned Savings	6.4	3.4	9.8	4.1	0.0	4.1	7.0	0.0	7.0
Schemes in Development	2.7	2.2	4.9			0.0			0.0
Total Savings	**9.1**	**5.5**	**14.6**	**4.1**	**0.0**	**4.1**	**7.0**	**0.0**	**7.0**
Board Savings Target	**9.1**	**5.5**	**14.6**	**9.4**	**3.1**	**12.5**	**9.7**	**3.2**	**12.9**

The financial plan is predicated on full delivery against the target set out in the plan (3% recurring plus 1% non-recurring, p.a.). As outlined above, there is presently a gap against the level of savings identified for 2026-27 and 2027-28 and plans for 2025-26 include a number of schemes in development.

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.

The phasing profile of planned savings as outlined in the financial plan is adjusted to rephase existing FIP schemes for 2025-26 and 2026-27 across the three year term including 2027-28. This is reflective of the high level of risk attendant on these plans. The level of schemes in development for 2025-26 and the gap against 2026-27 plans is in part a result of this reprofiling of existing plans to recognise the risk of slippage into 2027-28.

What this means in practice is that plans set out for 2025-26 and 2026-27 in the FIP programme will continue to be monitored on that basis, but that the financial plan is highlighting a level of risk in these plans and therefore identifying a need for additional plans to be identified across the three year profile in order to mitigate this risk.

As plans are developed further it is expected that the risk profile will continue to be reviewed and where possible plans deferred to 2027-28 will be brought forward and revert to the phasing set out within the FIP programme.

Savings plans will be monitored through the FIP Board and the risks attendant on these plans will be advised through regular monitoring reports to the Resources & Performance Committee.

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.

Appendix 2 summarises the planned savings identified to date.

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.

Cumulative Deficit

The Scottish Government have indicated that the brokerage mechanism will not be available in 2025/26 and thereafter. At this stage it is unclear how in year deficits will be treated and whether the Board will be directed to take additional actions not set out in the financial plan in order to deliver a balanced financial position in 2025/26. This issue remains subject to ongoing dialogue with Scottish Government.

At end March 2025 NHS Borders will have accumulated a brokerage liability of £50.3m at end March 2025. The position set out in the medium term financial plan would result in a further increase to the Board's cumulative deficit of £46.7m over the term of the plan resulting in an accumulated total deficit (inclusive of brokerage liability) of £97.0m.

Scenario modelling has indicated that – should 3% savings continue to be delivered annually over a longer term planning cycle – the Board would be in a position to achieve breakeven by 2030. This means that it is likely that repayment of brokerage would not be possible any earlier than that timeline.

The timescales for repayment of brokerage would be expected to be confirmed via negotiation with Scottish Government however it is likely this would require to be achieved over a number of years given the scale of existing commitments, irrespective of how future deficits are to be treated.

Budget Setting

In order to set a balanced budget over the term of the plan, the Board will require to increase the level of savings target incorporated within operational budgets. In order to retain current levels of engagement to the delivery of existing savings targets as set out in the FIP programme it is recommended that the approach to budget setting is as follows:

- Business Unit Savings targets for 2025-26 will remain as currently set out in the 2024-25 plan (i.e. 10% to be delivered over three years). This will mean that individual budget managers continue to plan for delivery in line with previously advised targets being 10% less any savings delivered in 2024-25; with a minimum of 3% recurring to be delivered in 2025-26.
- Expenditure budgets for 2025-26 will be set in line with available resources, with commitments above this level only to be budgeted following further review by the Director of Finance and to be financed through creation of an unallocated 'central' savings target. This central target will be delegated to accountable managers through the 2026-27 financial planning cycle.
- Projected cost pressures noted in the plan to be subject to assessment of potential management actions where possible and recommended for investment in the 2026-27 plan where this is considered necessary following outcome of quarterly reviews. This includes prescribing growth above 3% and other demand-led growth factors which are projected in the plan but which at this time are not yet realised in actual expenditure.

The proposed approach has been applied to the Indicative Budget Offer made to the Scottish Borders Integrated Joint Board and presented under separate cover to the NHS Borders Health Board meeting on 3rd April 2025.

Next Steps

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 liability and accumulated deficit presents a significant risk to the ongoing sustainability of NHS Borders.

Despite this, progress in 2024-25 has been encouraging and this is reflected in a positive assessment from Scottish Government on the progress delivered to date via ongoing discussions in relation to the Board's escalation status. Particular highlights noted include the significant reduction in agency use within NHS Borders across Medical and Nursing workforce, as well as the high watermark in recurrent savings

delivery in 2024-25, noting that the Board is expected to achieve its 3% savings target in full.

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 two weeks.

This in turn will inform any further development of financial recovery actions beyond the level of savings already expected to be achieved within the financial plan. This may also influence the level of operational performance which is expected to be achieved, should there be a requirement to take actions to reduce expenditure with detrimental impact upon service delivery.

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

The Resources & Performance Committee reviewed financial risk as part of the draft plan presented to the committee in March 2025. A full risk profile of the plan is reviewed quarterly as part of the quarterly review process. A separate risk register is maintained in relation to the Financial Improvement Programme (FIP).

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 6th March 2025. A briefing was provided to the Area Partnership Forum on 28th February 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, 6th March 2025
- Board Executive Team, ongoing review
- Senior Finance Team, ongoing review

2.4 Recommendation

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

The Board is requested to **approve its medium-term financial plan** for the period 2025/26 to 2027/28 on a provisional basis subject to final agreement with Scottish Government.

The Board is requested to **endorse the budget setting approach** set out in the paper.

It is recommended that the Board take **limited assurance** from this report, recognising the current status of the 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 2 – Summary Savings Plan

Appendix 1 – Draft Financial Plan

Summary of Revenue Outturn

Revenue Resource Limit (RRL)	2025-26 R £000s	2025-26 NR £000s	2025-26 Total £000s	2026-27 R £000s	2026-27 NR £000s	2026-27 Total £000s	2027-28 R £000s	2027-28 NR £000s	2027-28 Total £000s
Gross Expenditure - Clinical & Non-clinical	369,435	38,158	407,594	374,838	40,940	415,778	380,525	40,910	421,435
Less: Gross Income	14,697	5,525	20,222	14,697	5,525	20,222	14,697	5,525	20,222
Total Expenditure	**354,738**	**32,633**	**387,372**	**360,141**	**35,415**	**395,556**	**365,828**	**35,385**	**401,213**
Less: Total Non-Core RRL Expenditure	0	7,028	7,028	0	7,028	7,028	0	7,028	7,028
Less: FHS Non Discretionary Net Expenditure	14,896	0	14,896	14,896	0	14,896	14,896	0	14,896
Core Revenue Resource Outturn	**339,842**	**25,605**	**365,448**	**345,245**	**28,387**	**373,632**	**350,932**	**28,357**	**379,289**
Baseline Allocation	303,658		303,658	312,768		312,768	322,151		322,151
Anticipated Allocations: Rec/ Non-rec/ Earmarked	10,148	38,863	49,011	10,148	31,893	42,041	10,148	31,893	42,041
Core Revenue Resource Limit (RRL)	**313,806**	**38,863**	**352,669**	**322,916**	**31,893**	**354,809**	**332,299**	**31,893**	**364,192**
Forecast Variance against Core RRL	**-26,036**	**13,258**	**-12,779**	**-22,329**	**3,506**	**-18,823**	**-18,633**	**3,536**	**-15,097**
Forecast Variance (% of Core RRL)			**-3.6%**			**-5.3%**			**-4.1%**

	2025-26 R £000s	2025-26 NR £000s	2025-26 Total £000s	2026-27 R £000s	2026-27 NR £000s	2026-27 Total £000s	2027-28 R £000s	2027-28 NR £000s	2027-28 Total £000s
Financial Gap before Savings	**-35,146**	**7,721**	**-27,425**	**-31,712**	**378**	**-31,334**	**-28,298**	**315**	**-27,983**
Savings Target	9,110	5,537	14,646	9,383	3,128	12,511	9,665	3,222	12,886
Forecast Variance against Core RRL	**-26,036**	**13,258**	**-12,779**	**-22,329**	**3,506**	**-18,823**	**-18,633**	**3,536**	**-15,097**

Additional Funding / Expenditure

	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s
Additional Funding									
Uplift on baseline	8,638		8,638	9,110		9,110	9,383		9,383
NRAC Adjustment	7,104	0	7,104	0		0	0		0
New Medicines Funding		5,500	5,500		5,500	5,500		5,500	5,500
Other new allocations	6,682	5,500	12,182	0		0	0		0
Additional income	107	0	107	110		110	110		110
Total Additional Funding	**22,531**	**11,000**	**33,531**	**9,220**	**5,500**	**14,720**	**9,493**	**5,500**	**14,993**
Brought Forward Pressures									
Unachieved Savings (from prior year)	19,866		19,866	10,756		10,756	6,675		6,675
AfC Staff	1,482	2,060	3,542		2,122	2,122		2,185	2,185
Other Brought Forward Pressures	13,698	142	13,840	15,280		15,280	15,654		15,654
Total Brought Forward Pressures	**35,046**	**2,202**	**37,248**	**26,036**	**2,122**	**28,158**	**22,329**	**2,185**	**24,514**
Pressures									
Pay									
Uplifts									
Pay Uplift - AfC	4,231		4,231	4,593		4,593	4,731		4,731
Pay Uplift - Medical & Dental	1,208		1,208	1,244		1,244	1,281		1,281
Pay Uplift - Other	44		44	45		45	47		47
Total Uplift Pressures	**5,482**	**0**	**5,482**	**5,882**	**0**	**5,882**	**6,058**	**0**	**6,058**
Workforce									
AFC Reform (Nursing B5-6)	1,754		1,754			0			0
Other Staffing	3,057		3,057	1,500	3,000	4,500	1,500	3,000	4,500
Total Pay Pressures	**4,811**	**0**	**4,811**	**1,500**	**3,000**	**4,500**	**1,500**	**3,000**	**4,500**

	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s
Non Pay									
Prescribing									
Acute Prescribing	1,893		1,893	1,666		1,666	1,799		1,799
Primary Prescribing	2,616		2,616	2,302		2,302	2,486		2,486
Total Prescribing Pressures	**4,509**	**0**	**4,509**	**3,968**	**0**	**3,968**	**4,286**	**0**	**4,286**
Estates and Infrastructure									
Energy Costs	0		0	98		98	100		100
Other Estate Level Costs	184		184	191		191	198		198
Total Estate and Infrastructure Pressures	**184**	**0**	**184**	**288**	**0**	**288**	**298**	**0**	**298**
Digital									
Office 365	220		220			0			0
PLICS	20	75	95			0			0
Other National Programmes			0	500		500	500		500
Local Programmes	1,545	1,002	2,547			0			0
Total Digital Pressures	**1,785**	**1,077**	**2,862**	**500**	**0**	**500**	**500**	**0**	**500**
Service Level Agreements	1,218		**1,218**	1,268		**1,268**	1,306		**1,306**
National & Policy Decisions									
NSSC National Services	500		500	500		500	500		500
Employer National Insurance Contributions	3,176		3,176			0			0
Total National & Policy Decisions	**3,676**	**0**	**3,676**	**500**	**0**	**500**	**500**	**0**	**500**
Other Board Specific Non Pay									
Other Non Pay	965		965	989		989	1,014		1,014
Other Board Specific Non Pay	**965**	**0**	**965**	**989**	**0**	**989**	**1,014**	**0**	**1,014**
Total Non Pay Pressures	**12,337**	**1,077**	**13,414**	**7,514**	**0**	**7,514**	**7,904**	**0**	**7,904**
Financial Gap Before Savings	**35,146**	**-7,721**	**27,425**	**31,712**	**-378**	**31,334**	**28,298**	**-315**	**27,983**

Appendix 2 – Savings Plan

Detail of Planned Savings

	2025-26			2026-27			2027-28		
	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s
Service Redesign and Reform									
Service Review (Acute)	25		25	0		0	300		300
Service Review (Acute)	145		145	95		95			0
Service Review (Mental Health & LD)	310		310	300		300	500		500
Service Review Other)	0		0	0		0	1,829		1,829
Total Service Redesign and Reform	480	0	**480**	395	0	**395**	2,629	0	**2,629**
Workforce - Nursing									
Nursing Supplementary Staffing		350	350	0		0			0
Other Nursing Workforce	523		523	703		703	2,338		2,338
Service Review (Primary Care & Community)	16		16	11		11			0
Workforce - Vacancy Controls	125		125	0		0			0
Other Workforce Schemes			0	0		0			0
Total Workforce - Nursing	664	350	**1,014**	714	0	**714**	2,338	0	**2,338**
Workforce - Medical									
Medical Supplementary Staffing		500	500			0			0
Medical Locum Direct Engagement Savings			0			0			0
Medical - Job Plan Review	0		0			0			0
Medical - Professional/Skill Mix Review	100		100			0	25		25
Other Medical Workforce	308		308			0	400		400
Other Workforce Schemes	16		16			0	0		0
Total Workforce - Medical	424	500	**924**	0	0	**0**	425	0	**425**
Medical Locum Direct Engagement Utilisation % (at submission date)									
Workforce - Other									
AHP Direct Engagement Savings			0			0			0
Service Review (Corporate)	23		23	22		22			0
Workforce - Management & Admin Review	41		41	253		253			0
Workforce - Other	366		366	471		471	375		375
Other Workforce Schemes	54		54	38		38			0
Total Workforce - Other	484	0	**484**	784	0	**784**	375	0	**375**
AHP Direct Engagement Utilisation % (at submission date)									
Procurement									
Procurement - Contracts	167		167	150		150	150		150
Other Procurement Schemes			0			0			0
Total Procurement	167	0	**167**	150	0	**150**	150	0	**150**
Prescribing - Switches									
Acute	0		0			0			0
Primary	1,958		1,958	611		611			0
Total Prescribing - Switches	1,958	0	**1,958**	611	0	**611**	0	0	**0**
Prescribing - Acute									
Other Switches	76		76	0		0			0
Other Acute Prescribing Schemes			0			0			0
Total Prescribing	76	0	**76**	0	0	**0**	0	0	**0**
Prescribing - Primary									
Formulary Compliance	23		23			0			0
Other Primary Prescribing Schemes			0			0			0
Total Prescribing	23	0	**23**	0	0	**0**	0	0	**0**
Estates & Infrastructure									
Energy Cost Reduction 25/26	917		917			0			0
Energy Efficiency Schemes (GPSEDS)	374		374	10		10			0
Other Estates & Infrastructure Schemes			0			0			0
Total Estates & Infrastructure	1,291	0	**1,291**	10	0	**10**	0	0	**0**
Improvement Savings									
e-Payslips Savings			0			0			0
Digital Letters Savings			0			0			0
Total Improvement Savings	0	0	**0**	0	0	**0**	0	0	**0**
Non-Pay (Other) & Other Measures									
Commissioning Review	175		175	515		515			0
Other Non-Pay	633		633	775		775	1,046		1,046
Other Non-Pay	8		8	75		75			0
Service Review (Corporate)	52		52	52		52			0
Balance Sheet Flexibility		2,500	2,500			0			0
Non-Pay (Other) Schemes & Other Measures			0			0			0
Total Non-Pay (Other)	868	2,500	**3,368**	1,417	0	**1,417**	1,046	0	**1,046**
Total Planned Savings Schemes	**6,435**	**3,350**	**9,785**	**4,081**	**0**	**4,081**	**6,963**	**0**	**6,963**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
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 has been made to the IJB with recognition that the NHS Borders financial plan presents a deficit position of which an element is in relation to functions delegated to the IJB. It is therefore anticipated that the IJB will be unable to meet its statutory duty to present a balanced financial plan and that this will result in a subsequent request to the Health Board for additional support.

The budget offer has been presented as interim to the IJB with recognition that further dialogue is required prior to confirmation of final budget.

Health Board members are requested to approve the interim budget offer to the IJB and to remit negotiation of a final budget offer to the Board Chief Executive and Director of Finance.

2.2 Background

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 Finance Officer (CFO) 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.

Prior to 2024/25 this process has been amended through local practice such that the IJB financial plan has been the product of consolidation of Health Board and Local Authority plans with limited input from the IJB during the financial planning cycle. A commitment was made following agreement of the 2024/25 financial plan that this process would be revisited in advance of the 2025/26 financial plan.

This process has been reviewed during 2024/25 and changes implemented to support the preparation of a draft five year financial plan for the IJB which incorporates projected growth and savings requirements within partner organisations and sets out the financial framework for future IJB planning. At this stage there is further work required to fully integrate the strategic commissioning plans of the IJB with the Health Board and Local Authority plans and it is envisaged that this work will continue to progress during 2025/26.

Budget Offer

The Chief Finance Officer of the IJB wrote to the Directors of Finance of NHS Borders and Scottish Borders Council on 10th December 2024 to request that draft Payment Offers are received in January to allow the IJB time to consider the potential determination the allocation of budgets and savings plans across the Health and Social Care Partnership before 1st April.

Issue of the draft budget offer was delayed due to ongoing work on the Health Board's financial plan, however information to support the development of the IJBs draft financial plan was shared in advance of the formal budget offer.

A letter confirming the initial budget offer was issued by the Director of Finance to the Chief Finance Officer (IJB) on 6th March 2025. 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.

Budget Setting Methodology

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

This principle was reaffirmed by the Health Board in setting the 2024/25 budget and has been applied in the preparation of the 2025/26 budget offer.

Delivery of Financial Balance

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. By agreement between the Director of Finance and IJB CFO this recovery plan will be co-produced as part of work to agree a final budget offer to the IJB.

Should the actions identified in the plan not be sufficient 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'. Further to this the Scheme of Integration provides that the IJB 'should make repayment in future years following the same methodology as the additional payment'.

The IJB has a level of accumulated debt to the Health Board from additional payments made in prior years and for which NHS Borders has required brokerage support from Scottish Government. The level and terms of repayment for this support remain subject to further discussion between the Health Board and officers of the IJB.

Given changes to the Scottish Government's approach to brokerage it is likely that NHS Borders will not be in a position to agree an additional payment to the IJB until such time as there is agreement with SG in relation to the Health Board's own financial deficit and how this will be managed.

2.3 Assessment

Budget Offer

The Health Board will provide baseline resource of £175.5m to the IJB to undertake the functions delegated to it by the Health Board. This includes £32.2m of resources set aside for the large hospitals element and incorporates funding assumptions in relation to anticipated SG allocations as set out in the offer.

This represents the recurring base revenue budget provided to the IJB in 2024/25 amended for the following:

- NHS Pay Awards issued in 2024/25 and financed recurrently through the 2025/26 Scottish Government budget settlement.
- Expected pay uplift at 3% of base budgets pending confirmation of NHS pay awards for 2025/26.

- Provision for Employer National Insurance Contribution changes in line with UK Government budget, for which funding is anticipated at 60% of estimated costs as advised by Scottish Government and in line with resource allocation to Local Authorities.
- Additional support to recurring cost pressures identified during 2024/25, notably additional in year prescribing growth and adjustment to baseline for commissioned healthcare.
- Confirmation of recurring funding for previously approved A&E workforce plan.
- Provision for further growth in non-pay expenditure, as applied differentially in line with the Health Board's budget setting model. This includes increase of 3% to revised baseline prescribing budgets, and to funds passed through to Social Care; and 2.5% increase to non-pay budgets in line with CPI forecast at December 2024.

The plan also includes investment in Pharmacy Medicines Management team as an invest to save initiative to support delivery of prescribing savings.

Uplift to Primary Care budgets is expected to be advised separately and fully funded by Scottish Government.

A number of other allocations are expected to be received on a non-recurrent basis in 2025/26 and the budget offer includes 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.

Approval of the IJB Budget

The draft IJB budget was presented to the IJB at its meeting on 19th March 2025. The IJB was recommended to accept the payment offer from Scottish Borders Council and to acknowledge the indicative payment offer from NHS Borders. Further recommendation was made to approve the indicative 2025/26 budget and the IJBs medium term financial plan.

A further recommendation was made to remit the IJB Chair to write to the Chair of the Health Board and leader of Scottish Borders Council to request that as part of the next review of the Scheme of Integration that the statutory partners consider facilitating more of a pooled budget approach to support best value principles.

Savings Targets

The savings targets set out in the budget offer to the IJB represent a roll-forward of targets set within the 2024/25 financial plan and IJB budget offer, net of savings achieved during 2024/25. The level of savings target set out within the budget offer is £9.4m, being £5.4m in relation to HSCP delegated functions and £3.9m in relation to Set Aside.

Targets set in 2024/25 reflected the opening deficit within the Health Board's plan at April 2024 and were allocated at 10% of budget across both delegated and non-delegated health budgets in line with the previously agreed 'equity' approach to budget setting.

This approach is consistent with the principles adopted in the Health Board's financial plan. The Board's financial plan sets out a level of planned investment and projected cost pressures which would require additional savings targets to be set in order to finance projected growth above the level funded in the plan.

It is proposed that decision to increase delegated savings targets is deferred to the 2026/27 planning round in recognition of the significant challenge presented by existing targets, and to allow financial modelling in support of the Health Board's organisational and clinical strategies to be undertaken during the course of the next financial year.

It is therefore expected that any adjustment to the savings target delegated to the IJB will be considered through the financial planning process in advance of the 2026/27 budget offer.

IJB Financial Forecast 2025/26

The NHS Borders financial plan describes a projected deficit before savings of £27.4m in 2025/26. The element of this deficit which is applicable to IJB delegated functions is estimated at £15.4m. The net forecast after savings indicates an expected Health Board deficit of £18.3m, of which £10.1m is expected to be within the IJB.

This position excludes application of £5.5m of additional non-recurrent support from Scottish Government in relation to financial sustainability, which has been confirmed subsequent to the IJB budget offer being issued. Application of this funding will be considered in advance of a final budget offer (see 'next steps' below).

The forecast set out in the budget offer is presented below:

	HSCP Delegated Functions £000s	Set Aside £000s	Total £000s
Budget	143,265	32,200	175,466
Projected expenditure (before savings)	152,302	38,539	190,841
Projected Deficit before savings delivery	**(9,037)**	**(6,339)**	**(15,375)**
Anticipated Savings Delivery - Recurring (3%)	*2,495*	*1,439*	*3,934*
Anticipated Savings Delivery - Non-Recurring (1%)	*832*	*480*	*1,311*
Projected Deficit after Savings	**(5,710)**	**(4,420)**	**(10,129)**

The deficit before savings of £15.4m comprises £9.0m in relation to HSCP delegated functions and a further £6.3m in relation to Set Aside budgets.

The deficit after savings indicates a £10.1m deficit (£5.7m HSCP delegated; £4.4m Set Aside). This position requires that savings delivery is in line with in year targets set through the FIP programme, i.e. 3% recurring savings and a further 1% to be delivered on a non-recurrent basis. At this stage savings to address the full value of the target have not yet been identified and there is therefore a risk to the position set out in the budget offer.

Next Steps

A revised budget offer will be prepared following further dialogue between the Chief Executive and Director of Finance, and officers of the IJB.

The financial terms of this offer will include consideration of the level of savings delivery expected to be achieved, management actions in place to address cost pressures and to mitigate against slippage on savings delivery, application of funds held within the IJB reserves, and availability of additional resources via SG allocation or through virement from NHS Borders non-delegated budgets.

Beyond this it is expected that in agreeing a final budget offer, including any requirement for additional support, there will be agreement in relation to the outcomes to be delivered against delegated budgets, including actions in relation to management of delayed discharges and other relevant performance objectives, as well as the expected approach to implementation of the Buchan and Associates review of whole system capacity in health and social care.

Further dialogue will be required to determine any additional support available to the IJB in the context of the Scottish Government's confirmation that brokerage support will no longer be available to Health Boards and the implications of this position regarding NHS Borders' own financial position. It is unlikely that any settlement will be reached with the IJB until such time as this situation is resolved through the Health Board's dialogue with Scottish Government.

No agreement has been reached with regard to the terms of, and timescales for, repayment of the Health Board's brokerage liability and the prior and current year support to the IJB. This matter will be considered through ongoing dialogue and an updated position advised in advance of the 2026/27 financial planning round.

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 2025/26 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 2025.

The Director of Finance met with the Interim IJB Chief Financial Officer on 19th February 2025 to discuss the terms of the offer.

The terms of this offer have been presented to the IJB at its meeting on 19th March 2025.

2.4 Recommendation

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

The Board is recommended to approve the interim budget offer to the IJB, noting the terms of this offer and to remit to the Chief Executive and Director of Finance responsibility for negotiation of a final budget offer to the IJB which encompasses agreement of the outcomes expected by the Health Board in relation to the IJBs overall use of resources.

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 Finance Officer of the IJB presenting the Budget Offer from NHS Borders

NHS Borders

Newstead
Melrose
Roxburghshire
TD6 9DA

www.nhsborders.scot.nhs.uk

Via Email

Ms Lizzie Turner
Chief Financial Officer
Scottish Borders HSCP & IJB
Scottish Borders Council
Newtown St Boswells
Melrose TD6 0SA

Date 6th March 2025
Your Ref
Our Ref AB/BE

Email andrew.bone@borders.scot.nhs.uk

Dear Lizzie

PAYMENT REQUEST FOR 2025/26 FROM SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD (IJB)

In response to your letter of 10th December, I am writing to confirm the Health Board's initial budget offer to the IJB for the financial year 2025/26. In summary, the offer is as follows:

	HSCP Delegated Functions £000s	Set Aside £000s	Total £000s
Revised Budget before Savings	148,682	36,136	184,819
Savings Target b/fwd	(5,417)	(3,936)	(9,353)
Revised Budget	**143,265**	**32,200**	**175,466**

This offer is made in the context of the ongoing financial deficit facing the Health Board and a significant of this deficit remains within scope of functions delegated to the IJB.

You will note that an estimate of the financial challenge faced by the IJB in 2025/26 is set out later in this letter. This is intended to be indicative at this stage and further work will be required to fully assess the projected gap in 2025/26. I would expect this work will be undertaken in parallel with the discussions between the Chief Officer and Chief Executives' of partner organisations which will consider the expected outcomes to be delivered by the IJB against its available budgets.

Table 1 in the Appendix to this letter provides a summary of the overall budget outlining the key elements against a revised in year baseline budget, which incorporates increases to the initial budget offer made in March 2024 where funding has been made recurrent by Scottish Government and consolidated within the base during 2024/25, as well as any additional budget adjustments arising from NHS Borders internal budget setting process.

Comparison with 2024/25 initial budget
This offer represents an increase of £21.2m (14%) above the budget offer made in March 2024. Within this is £4.2m relating to general uplift to pay and non-pay expenditure, which is applied in line with the Health Board's budget setting model; £0.8m is anticipated in relation to Employer National Insurance Contribution (see below); funding of £2.6m in relation to cost pressures. The balance of this increase is in relation to movements to budget during 2024/25 which post-date the initial budget offer.

Budget Composition
The key elements of increase to the budget are as follows:

- Pay Policy – resources are modelled on the basis of 3% uplift to NHS directly employed staff, in line with Scottish Government Pay Policy. It is assumed that any further increase above this level will be reflected in additional allocation following agreement of pay settlements.
- Prescribing – baseline budgets are uplifted to reflect cost pressures identified within current forecasts for 2024/25, and a further 3% increase to expenditure above this level in line with the general uplift available to NHS Borders.
- Non-Pay uplifts – baseline budgets will be adjusted to address cost pressures identified in current forecasts for 2024/25. A further increase for general inflation adjustment to non-pay budgets is set at 2.5% in line with CPI forecast as at December 2024.
- Primary Care – uplift to primary care budgets is expected to be advised separately and fully funded by Scottish Government. No uplift is modelled within the current budget offer pending confirmation of this agreement.
- Social Care – it is assumed that NHS resources utilised to commission social care capacity will be uplifted in line with the general uplift applied to the Board's baseline budget (3%).
- Employer's National Insurance Contribution (increase). It has been confirmed that NHS Health Boards will receive funding at 60% of projected costs. This will be passed on in full in line with the Board's pay budget setting model.
- A&E Workforce – the baseline includes recurring funding for the increase to Emergency Department workforce previously advised as a cost pressure subsequently noted as a variation to the initial budget offer during 2024/25.
- Commissioned Healthcare – provision is made within the budget for an element of the predicted cost pressure arising from out of area placement of individuals with Learning Disabilities. See 'Cost pressures' below.
- Funding is provided to increase the Pharmacy Medicines Management team on an 'invest to save' basis, with expectation that this supports the delivery of prescribing savings.

Further detail on the composition of budget movements is provided in Table 2 within the appendix to this letter.

Future Investment
The Health Board's financial plan includes provision for further investment not yet agreed, and for which individual business cases would be required to progress through HB governance. This will include consideration of areas where investment is required to support performance improvement, transformational change, or to support sustainability of services.
These investments will be financed through the introduction of additional savings targets to be delivered over the medium term. At this stage no increase to savings targets delegated to the IJB is assumed in the

plan, pending further discussion regarding any potential investment impacting on the IJB and how this will be financed.

Medium Term Planning
You have also requested that the Health Board set out assumptions which will enable the IJB to develop its medium term financial plan. Per our discussions, this information has been provided separately and will continue to evolve through ongoing discussion.

Reserves
Per our separate discussions, details of the IJB reserve will be subject to ongoing discussion and it is my expectation that ring-fenced balances will be carried forward into 2025/26 for utilisation by the IJB.
I also anticipate that we will undertake joint review of these balances early in the new financial year with the intention of identifying any element of the reserve which may be released to support cost pressures within the health-delegated budgets prior to agreement of any further support required by the IJB to meet its statutory requirement to breakeven.

Projected Financial Gap
The table below sets out our initial forecast for 2025/26 in relation to health-delegated functions. This is indicative at this stage and I would anticipate figures will change following further discussion. The table compares the net budget (inclusive of savings) against projected expenditure inclusive of cost pressures, and with assumption around the level of actual savings to be delivered. There remains significant risk around this level of savings and how it will be achieved, and I would suggest that we pick up discussion on the detail of savings plans through our regular meetings.

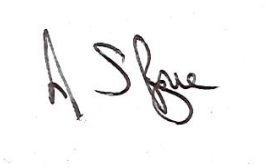
	HSCP Delegated Functions £000s	Set Aside £000s	Total £000s
Budget	143,265	32,200	175,466
Projected expenditure (before savings)	152,302	38,539	190,841
Projected Deficit before savings delivery	**(9,037)**	**(6,339)**	**(15,375)**
Anticipated Savings Delivery - Recurring (3%)	*2,495*	*1,439*	*3,934*
Anticipated Savings Delivery - Non-Recurring (1%)	*832*	*480*	*1,311*
Projected Deficit after Savings	**(5,710)**	**(4,420)**	**(10,129)**

At this stage this would indicate a requirement for £10.1m above the level of savings set out in the Health Board's plan. Before we agree any level of additional support available to the IJB I would expect we will have further discussion in relation to:

- Outcomes which the IJB is expected to deliver against the available resources
- Cost pressures and how these are managed
- Savings schemes and how these will be delivered
- IJB Reserves and how any flexibility will be utilised to mitigate the overall gap
- Potential further investment and how this is financed (i.e. additional savings targets)

I look forward to further discussion in due course.

Yours sincerely



Andrew Bone
Director of Finance, NHS Borders

Appendix 1 – Initial Budget Offer, Supporting Tables

Table 1 – INITIAL BUDGET OFFER 2025/26

	HSCP Delegated Functions £000s	Set Aside £000s	Total £000s
Recurring Base Budget before Savings	121,026	34,026	155,052
Additional Allocations anticipated within the baseline			
Primary Medical Services (GP Contract)	17,779		17,779
PCIP (GP Contract)	3,898		3,898
AFC Reform (Reduced Working Week Phase I)	281	169	450
Adjusted Baseline before Savings	**142,984**	**34,195**	**177,179**
Savings Target included in Base	(5,417)	(3,936)	(9,353)
Net Baseline	**137,567**	**30,259**	**167,826**
General Uplift	3,177	1,015	4,192
Anticipated SG Allocations	568	221	789
NHSB Cost Pressures	1,954	705	2,659
Revised Budget	**143,265**	**32,200**	**175,466**

Table 2 – BUDGET MOVEMENTS

	HSCP Delegated Functions £000s	Set Aside £000s	Total £000s
Baseline Budget excluding Savings	**142,984**	**34,195**	**177,179**
General Uplift			
NHS Pay Policy	1,671	903	2,574
Prescribing Uplift	800	84	884
Non Pay Uplift (net)	705	28	733
	3,177	**1,015**	**4,192**
Anticipated SG Allocations			
Employer NIC (assumed funding, 60% of estimated cost)	568	221	789
	568	**221**	**789**
NHSB Cost Pressures			
A&E Workforce 2024/25 - £1m included in base			0
Commissioned Healthcare (LD)	687		687
Prescribing 2024/25	698	705	1,403
Non Pays 2024/25	250		250
Pharmacy Medicines Mgt (Savings support team)	319		319
	1,954	**705**	**2,659**
Less: Savings Target B/fwd	**(5,417)**	**(3,936)**	**(9,353)**
Revised Budget	**143,265**	**32,200**	**175,466**

Table 3 – Risks / Pressures not included within the plan

	HSCP Delegated Functions £000s	Set Aside £000s	Total £000s
Medicines & Prescribing Growth	1,868	*195*	2,063
Surge Capacity		2,060	2,060
Out of Area Placements (LD)	1,373		1,373
Employer NIC (unfunded element, 40% of estimated cost)	379	148	526
Additional Cost Pressures & Growth	**3,620**	**2,403**	**6,022**

Table 4 – Reconciliation of Projected Gap

	HSCP Delegated Functions £000s	Set Aside £000s	Total £000s
Savings Targets b/fwd	(5,417)	(3,936)	(9,353)
less anticipated savings	3,327	1,919	5,246
Net Savings Gap	**(2,090)**	**(2,017)**	**(4,107)**
Additional Cost pressures & growth	(3,620)	(2,403)	(6,022)
	(5,710)	**(4,420)**	**(10,129)**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
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 12 March 2025

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 15.01.25

Borders NHS Board
Clinical Governance Committee
Approved Minute

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 15 January 2025** at 10am via Microsoft Teams

Present

Mrs H Campbell, Non-Executive Director
Dr K Buchan, Non-Executive Director
Mrs L Livesey, Non-Executive Director

In Attendance

Miss D Laing, Clinical Governance & Quality (Minute)
Mrs L Jones, Director of Quality & Improvement
Mr P Moore, Chief Executive
Mrs L Huckerby, Interim Director of Acute Services
Dr L McCallum, Medical Director
Dr S Bhatti, Director of Public Health
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Dr J Manning, Associate Medical Director, Acute Services
Dr I Hayward, Associate Medical Director, Acute Services
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
Dr C Cochrane, Head of Psychological Services
Mr S Whiting, Infection Control Manager

1 Apologies and Announcements

Apologies were received from:

Mrs F Sandford, Non-Executive Director (Chair)
Dr A Cotton, Associate Medical Director, Mental Health Services
Mrs S Horan, Director of Nursing Midwifery and Allied Health Professionals
Mrs J Campbell, Lead Nurse for Patient Safety and Care Assurance

Mrs H Campbell, Non-Executive Director deputising for the Chair.

The Chair confirmed the meeting was quorate.

The Chair welcomed:

Mrs K Hamilton, Chair NHS Borders Board
Mrs S Elliot, ADP Co-Ordinator (item 6.2)
Ms C Jones, Health Improvement Specialist, suicide prevention (item 6.3)
Ms C McElroy, Public Health Lead

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 and previously noted still stood.

3 Minute of Previous Meeting

The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 06 November 2024 were approved and adopted as holograph.

4 Matters Arising/Action Tracker

4.1 Matters Arising from the previous meeting were noted and Action Tracker was updated accordingly.

4.2 Mrs H Campbell asked that an action be added in relation to looking at correlation between delayed discharges and increase in falls. The action was added and Mr Williams agreed to look at Data and report back to the Committee via the Primary & Community board report.

4.3 Mrs Dickson gave and update on Action 6.1. Consideration had been given to sending Orthopaedic Consultants to Golden Jubilee to maintain competencies, however the number of joint replacements had increased through elective programme, so this action was not called for at this point.

5 Effectiveness

5.1 Clinical Board update (Acute) Services

5.1.1 Mrs Dickson reported the service continued to work under significant pressure across the site. Added pressure had come from various infection control challenges leading to closure of a number of bays. Despite pressures elective work had continued but this situation remains precarious due to bed pressures.

5.1.2 Piece of work in conjunction with social work and social care colleagues had been taking place to look at number of delays in the system. This work had taken some time and had an impact on the clinical staff and clinical nurse managers.

5.1.3 Workforce remained challenged in particular across smaller services. Work looking at vulnerable services is underway with considerable concern in cardiology, urology, dermatology, obstetrics, and gynaecology. Urgent cancer cases are prioritised with review clinics being affected. Following high media attention there had been a significant increase in requests for prostate biopsies, this is being monitored.

5.1.4 Falls with harm and pressure damage reporting had increased, action plans are in place consideration is being given to whether further work is required. A care assurance visit had taken place and significant improvement had been demonstrated.

5.1.5 Work is ongoing with Pharmacy Team to address any medicines management issues, wards have action plans to look at areas for improvement. Ward four is trialling medication investigation tool.

5.1.6 Tests of change taking place relating to SCN supervisory hours, time is also being used to embed patient flow and discharge processes which will be monitored over the winter months, there had been some impact due to an increase in staff absence. Care assurance work continues with a slight scale down due to demand in other areas.

5.1.7 Mrs Huckerby commented that a deep dive into vulnerable services across specialities had concluded and report will be going to BET, this will support the developing strategy. She noted that there had also been improvements seen in delayed discharge activity, this will be included in the Strategic Risk – Patient flow paper due to be tabled in March.

5.1.8 Discussion followed relating to harm due to lack of elective activity and increase in opiate prescription. Mrs Dickson commented that they may not have that level of detail, she also commented that as some of the orthopaedic procedures had changed slightly they may not be able to compare like for like to get an accurate picture. Mr Williams noted that they had seen an increase in demands on physiotherapy and podiatry possibly due to the longer waits for orthopaedic surgery as well as an increase in return visits to GP for repeat issues.

5.1.9 Mrs H Campbell commented she would be keen to see more detail on Consultant staffing issues and job plans. Dr McCallum gave a brief rundown on what NHS Borders is facing, largely due to the rurality and nature of the services provided at Borders General Hospital

5.1.10 Dr McCallum raised issue regarding CNM time and discussion followed around how this was being used, the organisation needs to be confident that the focus for this time is in the right direction. There are pockets of good practice and proactive CNMs but this should be across the piece.

5.1.11 Discussion then followed relating to delayed discharges and flow recognising that the model may not be quite there yet but work is ongoing and improvements are being seen. Involvement from all healthcare partners on ‘the shop floor’ is an area which needs to see improvement, working towards processes to inform that standard is complex and clinical leadership is needed to embed these processes.

5.1.12 Mrs Livesey enquired about reasons for targets not being met and if targets being set are achievable, she is seeking assurance that reasons are being analysed and a programme be put in place to achieve these in the future. Discussion took place on how the targets were set and possibly a conversation with Mr Myers may be helpful to understand the targets and expectations. Mr Moore gave a bit of background but further detail may be gained from all systems flow paper due in March.

5.1.13 Discussion regarding stroke and degree of urgency around stroke improvement as the subject is discussed regularly with no apparent improvement. Mrs Dickson commented there are There are focused improvement plans in place.

5.1.14 Mrs Livesey noted staffing and recruitment continuing to be a concern, she would like to see what actions are being put in place to address pressures on staff picking up gaps in staffing and workforce due to absences in particular around appraisal and training uptakes. The committee discussed at length all the issues relating to workforce pressures, different models of clinical care provision are being looked at to address shortfalls and provide a more resilient workforce in the future. Dr Young reiterated the impact of staffing and availability of clinical appointments has a massive impact on primary care.

5.1.15 Complaints appeared to be increasing although no new themes are arising Mrs Livesey would like assurance that there is a plan in place to address the increase. Mrs Dickson confirmed the main themes from complaints is communication and transitions of care, this is picked up at local governance meetings as well as with CMTs.

5.1.16 Mrs Jones commented the details relating to flow and delayed discharge will be picked up in the Strategic Risk – whole system flow paper, which is tabled for March, this will provide better assurance for the non-execs. Board development session had taken place relating to outpatients, a second session is planned which will include the pressure points from a clinical risk perspective.

5.1.17 ACTION: Better oversight of diagnostic testing in March report

5.1.18 The CLINICAL GOVERNANCE COMMITTEE noted contents of the report and confirmed **Limited Assurance**

5.2 Clinical Board update (PCS) Services

5.2.2 Mr Grieve gave the committee an overview of the report, he noted that there had been an increase in pressure on district nursing service to provide insulin administration, ongoing negotiation with diabetic team to rationalize this increase.

5.2.3 Pressure on the Berwickshire team had been felt to due sickness absence, however this had been mitigated with member of staff able to step up to cover parts of role. Leadership role recruitment has also been an issues but work towards supporting an individual to progress to ANP level is underway.

5.2.4 Digital platform called Chat Health had been introduced allowing children to access health support within schools this will be monitored and feedback to Committee.

5.2.5 Dental waiting times for theatre remain an issue with an increase in average waiting time, discussion with acute colleagues to reduce waiting times is ongoing. Mrs Guthrie assured the Committee the Acute team were looking at data to ascertain trends relating to cancellations of paediatric surgery and will report back results in the next report to the Committee.

5.2.6 Mr Grieve is awaiting update on recurrence of social care government funding for the care home support team he will keep committee cited on this issue.

5.2.7 Mr Grieve reported a positive improvement in relation to community Hospital medical support since the introduction of ANP module. Detail is contained in report.

5.2.8 Mrs H Campbell enquired about the vaccinations as it had appeared anecdotally there had been a reduction in uptake. Mr Clubb commented that National data showed a diminution with confidence in vaccination being low. National campaigns are not being shown here on television due to the channels here being different to other areas of Scotland. Further discussion followed in relation to encouraging uptake. There is due to be vaccination framework discussion to inform local action plan. Mrs Livesey enquired about possibility of data related to uptake both with staff and general public. Mr Grieve agreed to have discussion with Mrs Livesey to see what data she would like. He also assured the committee that vaccination programmes which were currently on hold due to winter pressures would be restarted once winter pressures had lessened.

5.2.9 Dr Bhatti reminded the Committee that there should be equal scrutiny on Primary Care as there is on the Acute sector. Mrs H Campbell invited Dr Bhatti to indicate any particular data he would like included in reporting.

5.2.10 Mrs Jones commented on the exceptional work in Kelso and the Knoll with better engagement with social care teams leading to significant improvement for patients

and patient flow. It is hoped this improvement work will be extended to Hawick and Haylodge.

5.2.11 Mrs Jones asked that Mr Grieve and possibly Mr Williams elaborate on the Home First in future reporting for the Committee to get better understanding of this significant piece of work.

5.2.12 ACTION: Discuss report content with Mrs Livesey & Dr Bhatti. Elaborate on home first in March report

5.2.13 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and **Limited Assurance**

5.3 Clinical Board update (MH/Psychological) Services

5.3.1 Mr Lerpiniere advised the Committee Mental Health Services were moving to Improvement phase on the core Mental Health Standards. Initially they will concentrate on engagement with care plans.

5.3.2 The service is building on work identified Nationally to improve risk assessment process.

5.3.3 Mr Lerpiniere reported that the service was meeting CAMHS Standards for category 2 patients. Dr Young commented he was pleased to see improvement in waiting lists, however, there continues to be a large number of referrals being rejected. There had been an increase in neurodivergent referrals who may or may not need CAMHS input but this cohort don't fit referral criteria and need additional support with nowhere to go, raising concerns for future provision of services.

5.3.4 Medical workforce issues continue to be challenging, updates are noted in the paper. NHS Borders are experiencing difficulties in recruitment, an update on medical workforce plan is being prepared. Dr McCallum noted her concerns relating to the risks around medical staffing, the situation remains fragile. There had been a significant piece of work looking at reducing agency spend which could cause further fragility in mental health medical staffing.

5.3.5 Mrs Livesey enquired about other possibilities to support the workforce, possibly using services like contract online. Discussion followed relating to the pros and cons of remote working, different models are being explored whereby support is being provided but non-medical staff however from a medical legal perspective there are some services only Doctors can provide. Dr Cochrane commented it is important to not over diagnose and recognise that referrals are often more about for support.

5.3.6 Mrs Livesey enquired about SPSO findings, Mr Lerpiniere offered to circulate the information.

5.3.7 ACTION: Circulate SPSO findings

5.3.8 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

5.3.9 Psychological Services

Dr Cochrane gave a brief overview of the report. The annual supervision survey had taken place and recommendations made details of these are in the report. Training on therapeutic approaches had now started following funding through the TED

Board.

5.3.10 Services pressures continue and performance remains the same as previously reported. Service review is underway, Dr Cochrane will keep the Committee informed on outcomes.

5.3.11 Risks and gaps had been reviewed, concerns on lack of inpatient psychology in adult and older adult mental health wards and rehabilitation. Mitigations are being put in place, risks will be considered through service review and added to risk register. Mr Lerpiniere commented the SBAR outlining risks, mitigations, and concerns raised by Mental Welfare Commission review was being taken to the Mental Health Quad.

5.3.12 Mr Williams Informed the Committee he and Dr Cochrane are working on Governance process around art therapies in relation to psychological therapy. They will keep the Committee informed on progress.

5.3.13 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

5.4 Clinical Board update (LD) Services

5.4.1 Mr Lerpiniere provided update on paper. Concerns remain the same as previously reported. Work is on-going on delayed discharges. This being very complex due to lack of appropriate facilities for a particularly vulnerable group of people.

5.4.2 The coming home project continues, first person has been placed and they are now looking for someone to share accommodation with them. As noted before the risk will be if placements breakdown as there is a lack of local learning disability beds. Negotiations with Lothian are ongoing to purchase a LD bed.

5.4.3 Issues around staffing vulnerability remain, due in part to extremely small resource of learning disability service.

5.4.4 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

6 Assurance

6.1 AHP Annual Report

6.1.1 Mr Williams gave an overview of the report. He commented that AHP services face a significant workforce challenge due to resilience of small services. This concern was taken to joint executive. Workforce planning is underway.

6.1.2 Care assurance framework was introduced within AHP services to allow teams to formulate what their individual services require to function efficiently with safe, quality and person centred ambitions. This framework will also look at regulatory requirements for their specialties and what metrics for effectiveness and impact on service are relevant to them, this in turn will provide assurance. Safe staffing legislation has given the services tools to demonstrate and articulate staffing levels quality improvement work is ongoing to address any gaps.

6.1.3 Outpatient waiting times are concerning particularly with children and young people services. Speech and language are a growing concern, service redesign has tried to address the waiting times but little improvement is being seen as yet.

6.1.3 Mr Williams completed a rehabilitation self-assessment with results highlighting gaps in community rehabilitation which has been fed into the delayed discharge project which is looking at early supported discharge services and frailty pathways to prevent admission or re-admission to hospital.

6.1.4 Mrs Jones commented she was pleased to see the care assurance work was developing and clinical measures were being considered relevant to each discipline. Concern remains around deconditioning due to availability of services and she is keen to have the IJB hear these concerns. She enquired if there was more Mr Williams felt could be done in relation to workforce modelling and skill mix. Discussion followed regarding this issue and the gaps being seen throughout Scotland in AHP services. Leadership structures are being considered as is AHP service delivery, it is hope the workforce planning will put forward some solutions.

6.1.5 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

6.2 Drug Deaths Annual Report

6.2.1 Mrs Elliot attended to present the report. There had been a significant reduction in drug related deaths, the lowest since 2013. She noted that whilst this is really positive news they are finding that they have no control over drug supply, any changes in this supply can quickly change the drugs picture. They are noticing a change in the drugs implicated in cause of death.

6.2.2 Robust partnership working with East Region Health protection Service had been established and liaison with Lothian providing a clearer protocol on who to contact and when.

6.2.3 Reduction in overdose had also been seen due to a well-established non-fatal overdose pathway.

6.2.4 Mrs Campbel enquired whether about the progress to appointing a DDRG chair. Discussion followed where Dr Bhatti assured the Committee this had been escalated to the joint executive team of the Health and Social Care Board. He also raised the issue of impending changes in the workforce which may have an impact on what can be provided.

6.2.5 The Committee commended all the good work that had gone on to achieve the reduction, recognising that not everything relating to drug deaths is in their gift to control.

6.2.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Significant Assurance**

6.3 Suicide Review & Prevention Annual Report

6.3.1 Mrs C Jones gave the Committee a brief overview of the report. She commented there had been real focus on local communities. Creating Hope Award scheme was launched encouraging communities to have a clearer understanding of suicide and its prevention.

6.3.2 Training and upskilling are vital to help communities identify and support those vulnerable to suicide. Participation in suicide prevention skills training was increased

and skill level, self-harm and suicide prevention for people who work with children and young people. Raising awareness of support available for those who have been bereaved by suicide is another area of focus

6.3.3 There had been an introduction of suicide surveillance system to record potential suicides, historical data is being uploaded to identify any trends and risk factors. This will identify any key areas of work.

6.3.4 Discussion followed relating to suicide and the connection with mental health it is noted that mental health is not always involved and there are other factors and mental distress that leads to attempting to take their life. Mr Lerpiniere had looked at themes and trends and did not see any that were repeated.

6.3.5 Mr Lerpiniere commented that risk assessments need to be much more personalised and conversational recognising what matters to the individual, however it is recognised that this can be quite challenging. He commended the work of the Public Health Team around raising awareness and engagement with communities.

6.3.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

6.4 Blood Transfusion Annual Update

6.4.1 Dr Hayward gave a brief overview of the report. She reported significant progress in service having appointed a permanent consultant haematologist. There had also been an improvement in mandatory blood transfusion training across all staff groups which she felt was linked to stabilisation of medical and nursing workforce.

6.4.2 Attendance at and regularity of Hospital Transfusion Committee had improved as had connections with NHS Lothian increasing access to more experienced blood transfusion staff.

6.4.3 Adherence to Scottish National Blood transfusion Service guidelines had also improved in line with recommendations from infected blood enquiry.

6.4.4 Dr Hayward noted limited access to Transfusion Practitioner was a concern in particular with completion of transfusion incident reporting. There is a national consultation on transfusion practitioner role is underway.

6.4.5 Attention was brought to issues within Laboratory services following introduction of laboratory management system. Dr Hayward noted her concern that they would not be able to meet standards required to meet expectations of MHRA.

6.4.6 Completion of training was also highlighted as an issue work is ongoing with C&PD to ascertain where there is shortcoming.

6.4.7 Mrs H Campbell enquired about dashboard and action plan as several dates had passed. Dr Hayward commented that several actions had been carried forward largely due to resource limitations within the lab. IT issues had been difficult to address also, due to IT not having the these on their workplan for this year which had a knock on effect on being able to complete actions. Dr McCallum commended the team who are working under pressure and noted that it was vital to the running of the hospital to have a safe transfusion service. Mrs Livesey asked if the impact of services had been appropriately escalated. Discussion followed regarding the impact of IT workplan not being aligned to clinical workplans and detrimental effect on

services, there is a SLWG being set up to ensure the IT issues are escalated and resolved.

6.4.8 Mrs Jones suggested an update in the acute paper on the progress of lab issues and challenges as well as delays in terms of prioritisation of clinical projects alongside the IT workplan. There are to be discussions at the Resource and Planning Committee in relation to this prioritisation.

6.4.9 ACTION: Laboratory issues to be included in Acute Board report, Mrs Dickson to discuss content with Mrs Jones

6.4.10 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

6.5 Maternity Services & Severe Maternal Morbidity Annual Update

6.5.1 Mrs Guthrie gave a brief overview of the report. She noted concerns regarding recruitment and long term sickness continue to have an impact on provision of services.

6.5.2 Healthcare Improvement Scotland (HIS) will be conducting maternity inspections throughout Scotland starting from January, the service will await the report and recommendations from HIS and share any actions as appropriate.

6.5.3 Mrs Guthrie commented it was important to recognise that maternity services care doesn't all happen in an acute setting that the vast majority is provided in a community setting, this has been raised nationally.

6.5.4 Short life working group has met in relation to maternity standards, it is expected that work towards meeting standards will be completed by October 2025.

6.5.5 CTG interpretation was highlighted on dashboard with one SAER being recorded in relation to this, work is ongoing with the Clinical Governance Team looking at this in more detail and will keep the committee update on any actions recommended. There does not appear to be any trends.

6.5.6 On a positive note the BFI gold has been maintained and an increase in breastfeeding rates had been seen great achievement given the pressures being experienced within services.

6.5.7 Dr McCallum highlighted the vulnerability of the service, particularly in relation to staffing and medical provision. It is vital to recognise that the ability to provide an obstetric service is wholly reliant on staffing and lack of service would have a massive impact on Borders. With declining birth rate it is vital to enter into conversations with regional partners on future of obstetric care. She commented that a meeting will take place in next few days and they expect an options appraisal will be required. Concerns need to be highlighted to the Board as soon as regional discussions are completed.

6.5.8 The Chair asked if an update should come to the Committee sooner than the annual report, it was agreed that any movement on issues regarding obstetrics will be reported through the acute report to the Committee.

6.5.9 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

7 Patient Safety

7.1 Infection Control Report

7.1.1 Mr Whiting attended to present the Infection Control Report. He drew attention to a couple of points noted in the report. An Internal Audit report relating to infection control had been submitted and considered by the Audit and Risk Committee who will continue to have oversight in terms of update and progress of action plan. This had also been discussed at the NHS Borders Operational Planning Group.

7.1.2 Highlighted issues and actions were being progressed and discussed with all relevant departments. Public Health is reconvening a group to oversee development of patient pathways relating to consequence of infectious disease and occupational health are picking up action relating to FFP3 face fit testing.

7.1.3 Mr Whiting noted that there had been an increase in compliance with infection control audits and acknowledged the hard work it had taken to achieve this.

7.1.4 Mrs H Campbell commented there did not appear to have been any improvement in relation to catheter associated infections Mr Whiting explained that testing of community nurse led removal of catheter had taken place and review of data to see if there had been a shift will be reported to the next CAUTI group in February.

7.1.5 Mrs Jones asked Mr Whiting to keep the Committee cited on any exceptions in relation to progress toward internal audit action plan.

7.1.6 Mrs Livesey raised concern relating to governance and reporting highlighted in Internal Audit report, discussion followed where Mr Whiting invited discussion on content and detail in his report to the Committee. Mrs Jones commented that reporting should be proportionate, detail is provided to the Infection Control Committee and a summary of that detail is reported to Clinical Governance Committee. It was agreed by the Committee that exception reporting on progress towards actions would be appropriate.

7.1.8 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

8 Person Centred

8.1 Patient Feedback Annual Report

8.1.1 Mrs Jones presented the content of both the annual report and bi-yearly Patient Feedback Reports. GP complaint numbers are noted in the Annual report. Feedback from sources like Care Opinion are also noted, the majority is positive, any negative feedback is followed up on and anyone noting critical points are encouraged to bring these up via the complaints process so the organisation is given the chance to act on the information formally.

8.1.2 Mrs Jones noted although there had been two years of heightened demand for formal complaint investigations reduction had been seen in the last six months. One of the main themes had been around timeliness of access to elective treatment.

8.1.3 Response times had improved and were now sitting at 30 days, the team continue to work to bring that down to the 20 day target.

8.1.4 Mr Grieve noted he was keen to explore looking themes for Primary Care reporting. he asked if it would be possible to have support from the Feedback & Complaints

team to achieve this and enable them to target improvements. Mrs Jones agreed to look at capacity of the team with a view to working towards providing this level of information. Dr Cochrane suggested the trainee psychologists may be able to assist as part of their training.

8.1.5 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

9 Items for Noting

9.1.1 The Clinical Governance Committee workplan for 2025/26 was presented for noting. Mrs Jones commented there had been large numbers of deferrals this year leading to changed agendas and re-tabled items at last minute. This is difficult due to the size and nature of Committee business commitments. She asked that members review the workplan and inform the secretariat if there are any obvious issues with meeting the timings on the plan.

10 Any Other Business

There were no further items of competent business to record.

11 Date and time of next meeting

The chair confirmed that the next meeting of the Borders NHS Board's Clinical Governance Committee is on **Wednesday 12 March 2025** at **10am** via Teams Call.

The meeting concluded at 12:54

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Quality & Clinical Governance Report - February 2025**
Responsible Executive/Non Executive	**Laura Jones - Director of Quality and Improvement**
Report Author:	**Julie Campbell - Lead Nurse for Patient Safety and Care Assurance** **Justin Wilson - Quality Improvement facilitator - Clinical Effectiveness** **Susan Hogg - Patient Experience Coordinator** **Susan Cowe - Senior Project Officer - Covid 19 Inquiries**

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 NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

2.1.1 This exception report covers key aspects of clinical effectiveness, patient safety and person-centred care within NHS Borders.

2.1.2 The Board is asked to note the report and detailed oversight on each area delivered through the Board Clinical Governance Committee (CGC).

2.2 Background

2.2.1 NHS Borders, along with other Boards in Scotland, continue to face pressures on services as they work towards reducing waiting times in planned care services and delays across the unscheduled care system. 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 12 March 2025 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. Delayed discharges across the health and social care system remains a consistent issue raised by each clinical board and members were keen that this position and its impact on quality of care, access to emergency care, elective and specialist beds is not normalised and continues to be escalated to NHS Borders Board and the Integrated Joint Board (IJB) for further collective action.

2.3.2 The CGC considered a paper from Primary and Community Services. It was raised to the committee that there are works underway to address Reinforced Autoclaved Aerated Concrete (RAAC) in the Knoll Hospital. The committee noted the rapid work undertaken to relocate both general practice and inpatient services and the collaboration across teams to achieve this. It was noted that this has led to a postponement of the tendering for Duns Medical Practice. It was highlighted that winter vaccination uptake for NHS Borders is the highest in mainland Scotland and the second highest for under 18s although the uptake is still low. Concerns were raised to the committee around dental access for paediatric inpatients and the committee requested an update on the plan to address this for the May 2025 committee meeting. District Nursing Staffing Challenges were highlighted to the committee. The committee were advised that work is underway to look at skill mix opportunities to support the work of the teams. The committee acknowledged changes in the Primary and Community Service Clinical Governance structure to revert to the previous model. This was welcomed to create adequate time and focus on clinical governance issues. and meetings to allow for better discussion on CG issues. Areas of good practice were also highlighted to the committee. These included the informed care approach being led by Allied Health Professionals, the progress of the phase two of the Hospital at Home service and the work underway in community hospitals to ensure effective patient flow and reduce length of stay and deconditioning. The committee took **limited assurance** from the report.

2.3.3 The CGC received a report from Mental Health and Psychological Services. It was highlighted to the committee that the demand on Mental Health services continues to remain high. The committee were concerned about the challenges within the service caused by this high acuity and also the growing expectation of mental health services for particular pathways. The committee noted that the service had recently submitted a Mental Health self-assessment to the Scottish Government setting out key areas of development for mental health services. The committee noted the Mental Welfare

Commission have provided positive results around patient experience in Huntlyburn, with five recommendations. It was noted by the committee that risks around workforce remain, with the medical workforce plan currently under review. The committee noted that support is being offered for completion of appraisals, the committee were pleased to note this was being focussed on areas with poor compliance. The committee remained concerned about the growing demand in the Child and Adolescent Mental Health Service that there are long waits for those with neurodevelopmental disorders following the initial appointment. The committee welcomed the work commissioned by the Integrated joint Board to look at wider provision across agencies to support neurodiversity and where keen for an update on how this might impact on health services. It was highlighted to the committee that members of the mental health team had contributed to a Fatal Accident Inquiry in February and awaited the determination of the inquiry later this year. The committee noted that Psychological Services Clinical Governance group is working well. It was highlighted to the committee that the Scottish Government Psychological Therapy Service Specification self-assessment tool will be concluded by the end of the financial year. The committee were pleased to note that shared governance structures are in place between Psychology and Allied Health Professions to ensure effective oversight of all psychological therapies. It was noted that funding for training within Psychological Services has been gained. The committee was concerned with the national workforce issues which have affected trainees and were keen for an update on this area. The committee took l**imited assurance** from the Mental Health report and **moderate assurance** from psychological services.

2.3.4 The CGC received a report on Learning Disability Services. The committee noted that the service has secured a bed within NHS Lothian to enable an out of area patient to return for local care. This forms part of the coming home programme and plans were detailed of placements for another group of patients. The committee were concerned to hear how delayed discharges were impacting on the service and patient experience, relating to unsuitable accommodation or waits for packages of care. A short-life working group has been established to explore this, with the discharge pathway being adapted. It was highlighted to the committee that the service has received the highest number of referrals for a single year. The committee acknowledged that a mortality review tool has been developed by the learning disability team and were keen to hear of the learning from this review approach. The committee took **moderate assurance** from the report.

2.3.5 The CGC received a report on Acute Services. Concerns around the pressures across the acute site were highlighted, with unfunded surge beds still open and a knock-on effect within Emergency Department including long waits for admission. The committee noted that there is work underway to build the Acute Assessment Unit model. The committee remain concerned with the access to specialist beds in the Borders Stroke Unit. A full report will come to the committee in May 2025 but the committee would like there ongoing concern to be raised for consideration of what choices the Board has to improve this area. The committee recognised that whole system flow is a fundamental factor in this issue. The committee explored the areas of service pressure resulting in particular from medical workforce availability and noted the innovative work underway but the fragility of some services. The committee expect to receive an update on the vulnerable services work in May 2025. The committee noted that performance in Radiology to keep waits for diagnostic testing down have been reliant on additional non-recurring funding and that this matter needed to be considered in the longer-term planning as demand continues to grow.

The committee recognise the positive impact diagnostics has on onward patient pathways and has been critical to cancer pathways. The committee noted the issues in the urology pathway resulting from a sharp increase in demand thought to be due to public campaigns and also pressure points on diagnostics in the urology pathway and access to tertiary care. This was an area the committee wished to remain under review recognising this had been escalated in regional discussions. The committee acknowledged that sickness absence remains high, although there has been improvement in this area. The committee were pleased to note that the hip fracture pathway is performing well, with the team receiving the Golden Hip Award. The committee also noted the pressures in laboratory services and wished to have a regular update on progress to address gaps required for service accreditation. The committee took **limited assurance** from the report recognising the significant pressure in the acute system.

2.3.6 The CGC considered the Children's Services Network Annual Report. The committee noted that staff absence had hindered network meetings from taking place but were pleased to note that progress had been seen within some areas. The committee acknowledged that the Bear Care Opinion for Children had been launched with some success and that this now forms part of the discharge letter to allow children to provide feedback. The Trauma Informed Workforce is progressing, and Baby Friendly Initiative standards are being maintained within the service. This work all falls under the delivery of The Promise which is a multi-agency approach to improving services for children and young people. The committee noted the report and took **moderate assurance** from the report

2.3.7 The CGC received the Child Death Annual Review. This was a new report which accompanies the Child Death review process introduced across Scotland over the last two years. The committee acknowledged that numbers are small but welcomed the rigour of the review process to understand learning from both expected and unexpected child deaths. The committee noted the alignment of the child death review process to other systems of review such as the Significant Adverse Event (SAER) process and multiagency child protection reviews. It was also highlighted to the committee that NHS Borders is unable to quantify child deaths in migrant communities as information is not always available, but it was noted that engaging with the national group may help with this discussion. The committee were pleased to note that a Standard Operating Procedure was now in place for deaths of 16 and 17 year olds. The committee noted the report and took **significant assurance** from the report.

2.3.8 The CGC considered the Mortality review annual report. As noted in previous years reports the death rate in the Scottish Borders has remained fairly stable but there continues to be a trend of an increased number of people dying in a hospital setting as opposed to in the community. This is likely to be reflective of system pressures being experienced across the health and social care system. The committee noted however, that there has been no increase in deaths overall. There is an appetite to consider deaths outwith 30 days of admission for the 2025/26 sampling approach which may increase learning. The committee were pleased to note that this work is aligned to the values based health and care programme and the workstreams to increase out of hospital models such as adult social care reablement, home first early supported discharge, hospital at home, palliative care provision and the work on treatment escalation planning. The committee noted the report and took **moderate assurance** from the report.

2.3.9 The CGC considered the Strategic Risk report on whole system flow. The current length of stay was highlighted, with discussion within the committee on how to improve this. It was acknowledged by the committee that work was focusing on reducing pressure in the Emergency Department by improving processes across all teams ensuring everyone was carry out the steps needed to plan for timely discharge. Daily review meetings are in place to support this process. The committee were pleased to note that governance processes are currently being refreshed with metrics being revisited to give the most accurate information and noted the shift in occupied bed days from delays. NHS Borders is taking part in the national Discharge without Delay programme. The committee understood that work was underway to look at how temporary surge areas could be closed to ensure patients were being cared for in the correct location to prevent deconditioning whilst awaiting social care. The committee noted the report and welcomed the progress in this area but took **limited assurance** recognising the significant strain on services from the level of delay.

2.3.10 The CGC received an update on Patient Safety Programme Annual Report. The committee discussed the breadth of work underway in the proactive patient safety programme and how this links to the learning from patient experience, adverse events, risk and activities in the clinical effectiveness programme. The committee recognised that the clinical excellence work is a programme of activities which never stop to continue to maintain safe and effective care as staff change and evidence develops. The committee noted the quality improvement work in paediatric service which has taken a deep dive into the use of Paediatric Early Warning Scoring. The understanding gained from this work has led to changes in the clinical approach within the paediatric ward and also to the standard used in the monthly audit programme. This has resulted in a dip in compliance but improved clarity of approach of the standard the team aim to deliver. The committee noted the expected improvement this area. NHS Borders hosted a visit from Healthcare Improvement Scotland relating to the perinatal improvement programme involving teams from Maternity, Neonatal and Paediatrics. There was excellent feedback on the local improvement work underway and sharing of initiatives from other areas. The committee noted that discussions have commenced with Mental Health Services and the Emergency Department to consider quality measures applicable to them for development of their existing quality dashboards. It was highlighted to the committee that the Excellence in Care Quality of Care review process has now been tested, and a local approach is being agreed to embed this consistently. The committee agreed a position of **moderate assurance**.

2.3.11 The CGC received the Adverse Event Overview report. The committee discussed the approach to SAERs and noted the developed of an updated version of the National Framework for the Management of Adverse Events. It was noted by the committee that the NHS Borders Adverse Event Policy is aligned to this framework and will be refreshed in line with the new amendments. It was noted that there has been extensive national discussion about the aspirational timescales set out in the framework for the delivery of SAERs. The committee noted the complexity of this and the circumstances where these timescales are not always appropriate to ensure adequate engagement of patients and families. Those leading SAERs highlighted the concern that SAERs are increasingly used for purposes beyond which they were intended outwith the NHS and were concerned about the additional workload this creates and creep in scope of the purpose of SAERs. This has been feedback in

discussions with Scottish Government and external partner agencies. The committee agreed a position of **significant assurance** in relation to the systems and processes in place for adverse event management**.**

2.3.12 The CGC received the Healthcare Acquired Infection (HAI) Scribe Action plan resulting from the commissioned internal audit into this area. The audit made 12 recommendations for NHS Borders surrounding HAI-Scribe. The committee noted that there were 27 actions from these recommendations, with 23 now complete. The 4 outstanding actions are due to be concluded by the end of April 2025. The committee noted the report and took **moderate assurance** from the report.

2.3.13 The Annual Public Health updated tabled for meeting was postponed, this meant the Business for 2024/24 was incomplete. A full report will come to Committee in May at the start of 2025/26 workplan.

2.3.14 Patient Safety and Care Assurance

2.3.15 Adverse Events:

Figure 1 shows all NHS Borders reported adverse events for the period January 2018 to October 2024:

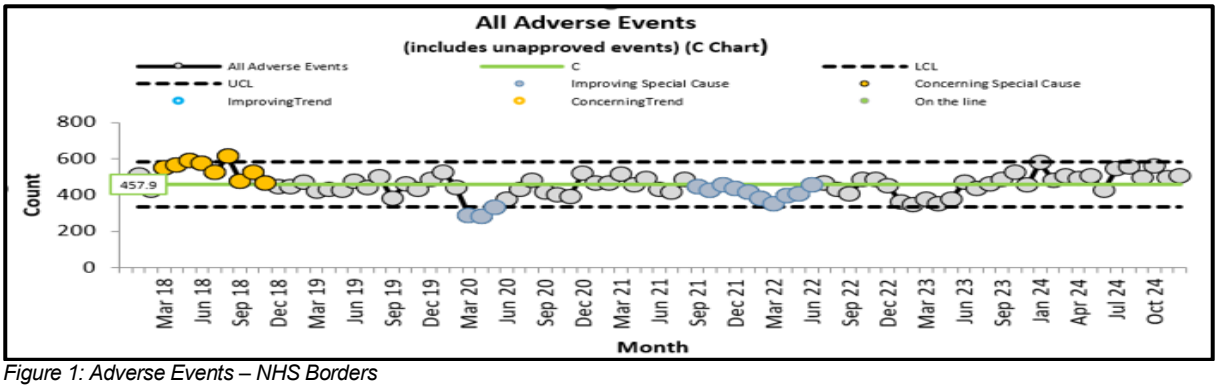


Figure 1: Adverse Events – NHS Borders

2.3.16 The new Framework for Learning from Adverse Events in NHS Scotland has been published in February 2025 by Healthcare Improvement Scotland (HIS). The framework has been developed in collaboration with HIS, NHS Scotland boards and key partner organisations The framework provides guidance and templates for managing adverse events. Its aim is to enhance the review process for patients, families, and staff affected by significant adverse events. The NHS Borders Adverse Event Management Policy is due for renewal in January 2026 and will be updated in line with this guidance.

2.3.17 Deteriorating Patient

2.3.18 Figure 2 shows the Cardiac Arrest (CA) rate for the Borders General Hospital (BGH) showing normal variation:

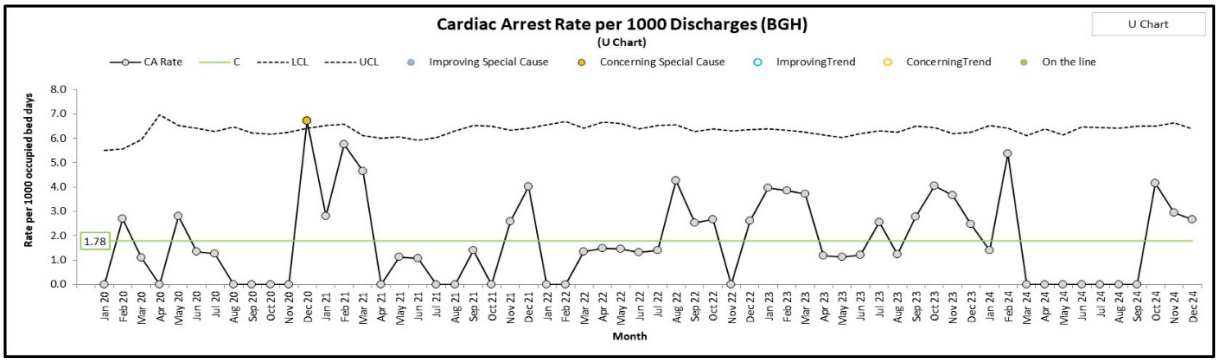


Figure 2: Cardiac Arrest Rate – Borders General Hospital (BGH)

2.3.19 Each CA was validated by a senior clinician and a proforma has been completed. A new proforma has been developed for trialling during CA reviews in 2025. The Resuscitation Committee plan to review these proforma's to identify common themes or omissions in care. Learning will also be shared with the Deteriorating Patient Group to enable any appropriate adjustments to local systems and processes for recognition and response to deterioration.

2.3.20 Learning from a recent SAER identified errors in the clinical observation of respiratory rate. The ward core audit programme has a number of measures relating to care of the deteriorating patient but this learning would not have been identified specifically through the audit programme. The patient safety team have been carrying out some spot checks in this area and this may be a measure which will be added to the core ward audit for a period of time. The Deteriorating Patient Group are holding a workshop in April 2025 to review our approach to recognition and response to deterioration to ensure everything we do is still working well and to plan any improvements we need to make to systems and processes or our educational approach.

2.3.21 An escalation board is currently being tested in Ward 5. The board aims to provide a visual management system to inform staff how to appropriately escalate deterioration. The learning from this piece of work will be considered at the workshop to consider application in other areas.

2.3.22 Falls

Figure 3 shows normal variation on NHS Borders fall rate per 1000 occupied bed days (OBD) across acute adult inpatient areas. The NHS Borders falls rate sits above the average for NHS Scotland which is not case mix adjusted for age and case mix:

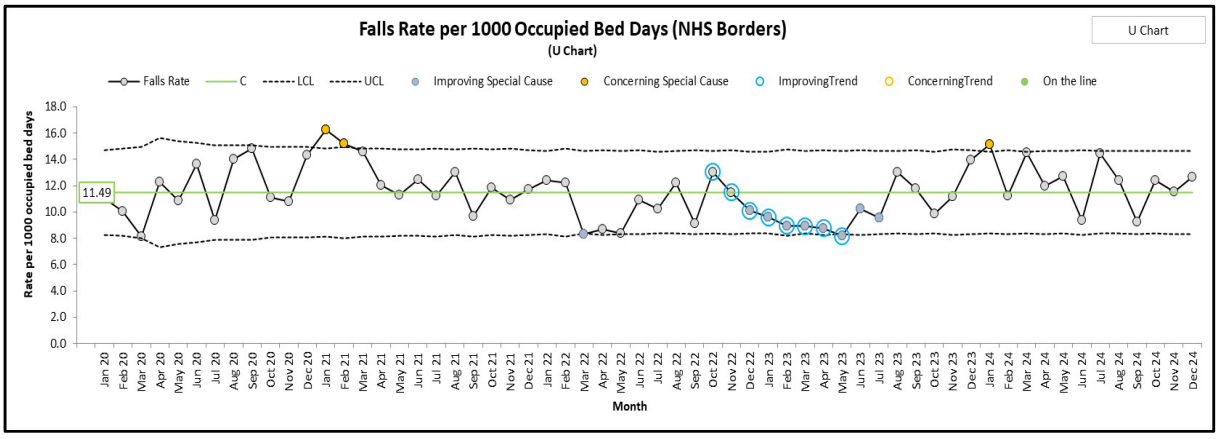


Figure 3: Falls Rate – NHS Borders

2.3.23 The Patient Safety Quality Improvement Facilitator (QIF) continues to validate all inpatient falls within NHS Borders to ensure appropriate grading and review. These events are reported to the Falls Steering Group as per our local governance structure, which then focuses on improvements.

2.3.24 Figure 4 shows the NHS Borders rate of falls with harm per 100 OBDs:

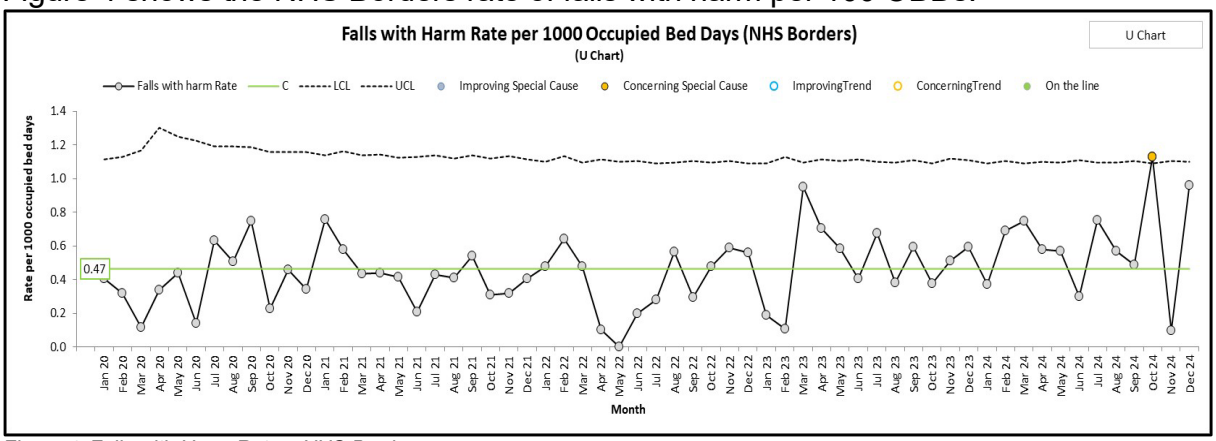


Figure 4: Falls with Harm Rate – NHS Borders

2.3.25 The Community Hospital teams are committed to falls prevention and management and have developed their own falls driver diagram to focus their improvement work as detailed in figure 5:

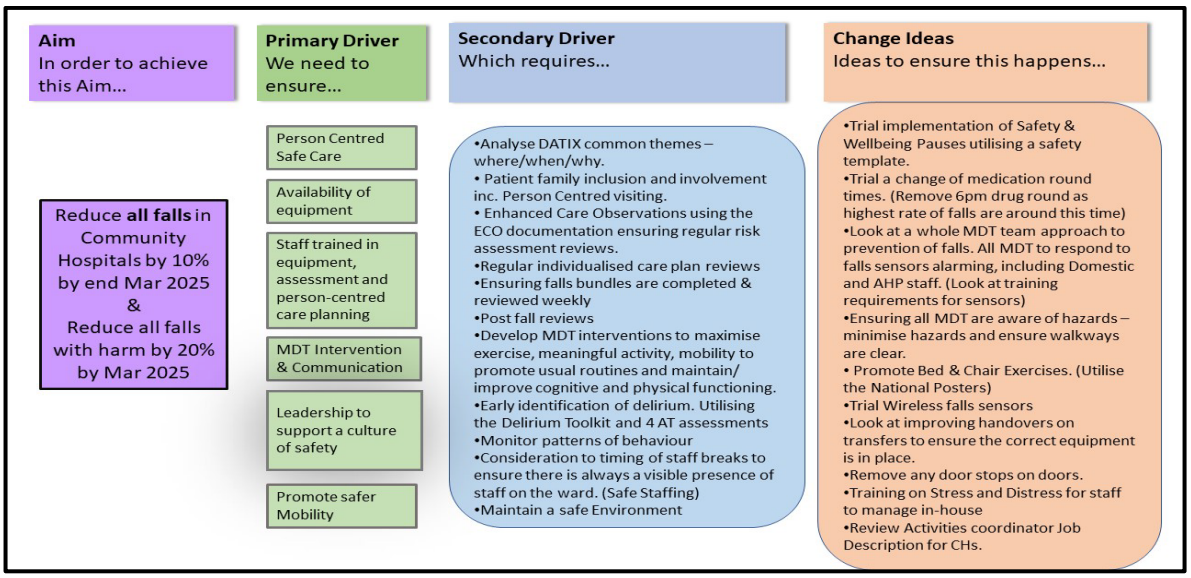


Figure 5 – Community Hospital Falls Driver Diagram

2.3.26 Pressure Damage

Figure 6 shows the rate per 1000 OBDs of developed pressure ulcers Grade 2 and above rate across NHS Borders showing normal variation with special cause in December 2024:

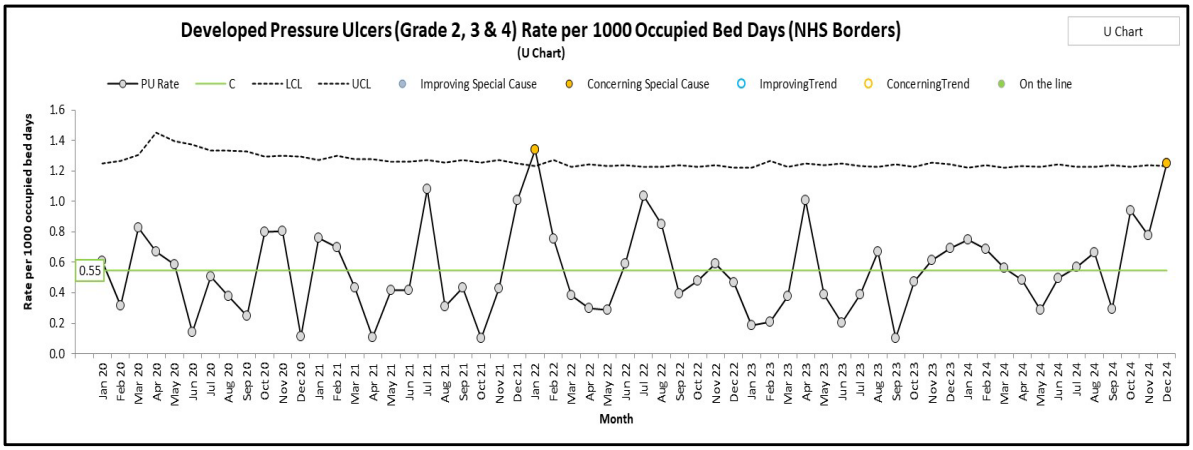


Figure 6: Developed Pressure Ulcer – NHS Borders

2.3.27 The Patient Safety QIF received approved funding from The Difference to purchase shatter proof pocket mirror for nursing and medical staff across the BGH. The aim is to reduce avoidable developed pressure damage, following evidence confirming the difficulty assessing heels. The mirrors provide a 360-degree view of the heel and skin.

2.3.28 Priorities for Tissue Viability includes ongoing education for staff, the Tissue Viability Nurse Specialist continues to support the project 'Extension for Community Healthcare Outcomes' (ECHO), which involves delivering regular education in care homes on recognising and grading pressure ulcers, simple dressing and escalation. Education also continues around the NHS Borders Wound Formulary with dates confirmed throughout 2025 scheduled.

2.3.29 Next steps are the development of the Over-Granulation Pathway and Fungating Wound Pathway. These new pathways should provide consistency in care and improved patient outcomes, cost savings and reduced waste.

2.3.30 **Food, Fluid and Nutrition**
The development of the Enhanced Oral Mouth Care Guidelines is underway. This includes how to order equipment, including small-headed baby toothbrushes. The Patient Safety QIF and the Oral Health Team are currently finalising the ordering procedures and guidelines for their use and distribution. Ongoing education is being provided during Fundamentals of Care study days and across BGH.

2.3.31 The Patient Safety QIF and the Catering Team are working together to review errors relating to patient meals. Errors have been identified in the completion of menu cards leading to meals with allergens or incorrect dietary modifications being ordered for patients. This concern has been escalated to the Food, Fluid and Nutrition Steering Group for oversight and improvement action.

2.3.32 Following a recent SAER communication between domestic and nursing staff regarding drinking assistance has been enhanced, with updates to the Multidisciplinary Assessment and Communication (MAC) booklet and design of a communication poster. An alternative design of drinking vessel, which are more ergonomically friendly for patients has now been approved and to be rolled out across NHS Borders.

2.3.33 Excellence in Care (EiC) Quality of Care (QoC) Review Guidance

The Lead Nurse for Patient Safety and Care Assurance is working in collaboration with individual Associate Directors on a system to coordinate QoC reviews across all nursing families and inpatient areas. This approach will be based on the learning from testing the new QoC review approach over the last six months.

2.3.34 Monthly Care Assurance Visit's (CAV) are expected to be scheduled by the SCN / CNM, using the CAV Template, which incorporates 16 elements of the EiC framework. The quality management system approach enables multi-professional teams to gain a deeper understanding of the standards and quality of care that is being delivered in their area, ultimately informing the sharing of good practice and enabling improvement.

2.3.35 A second full QoC review was commissioned within the Medical Assessment Unit (MAU), BGH on 4 March 2025. This was led by the Associate Director of Nursing for Acute and the Lead Nurse for Patient Safety and Care Assurance.

2.3.36 Hospital Mortality

NHS Borders Hospital Standardised Mortality Ratio (HSMR) for the 23rd data release under the new methodology is 1.13. This figure covers the period October 2023 to September 2024 and is based on 606 observed deaths divided by 537 predicted deaths. The funnel plot in Figure 14 shows NHS Borders HSMR remains within normal limits based on the single HSMR figure for this period:

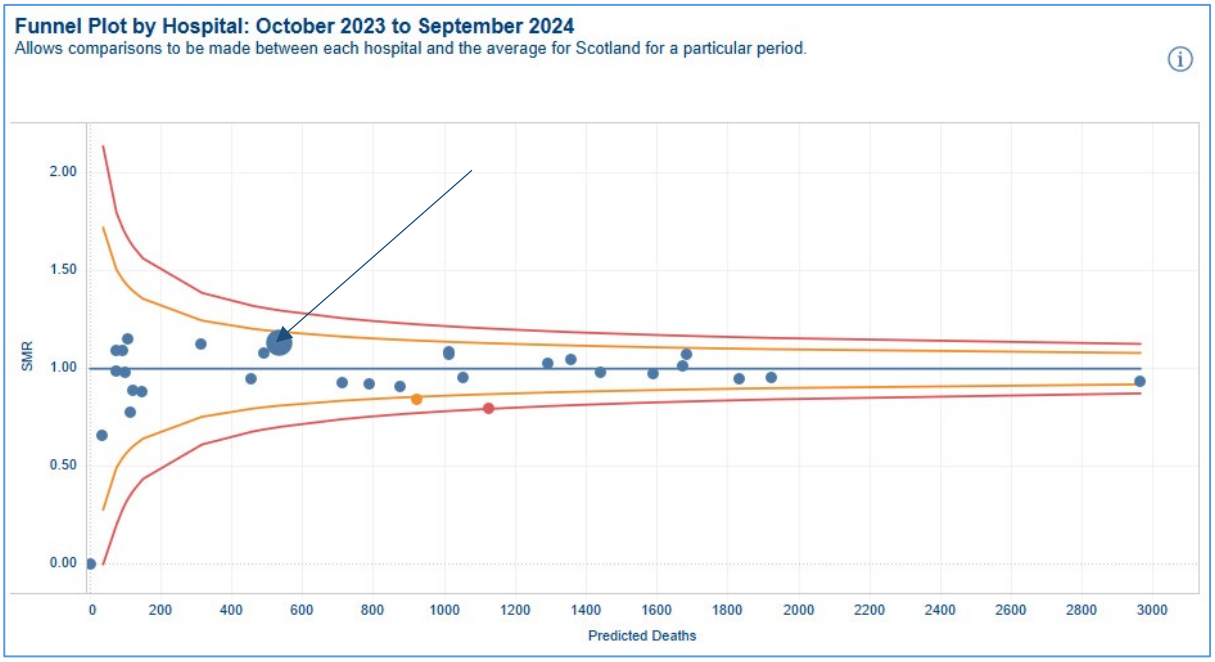


*Figure 7 – HSMR Funnel Plot NHS Borders - *Contains deaths in the Margaret Kerr Palliative Care Unit*

2.3.37 NHS Borders crude mortality rate for quarter July 2024 to September 2024 was **3.7%** and is presented in Figure 8 below:

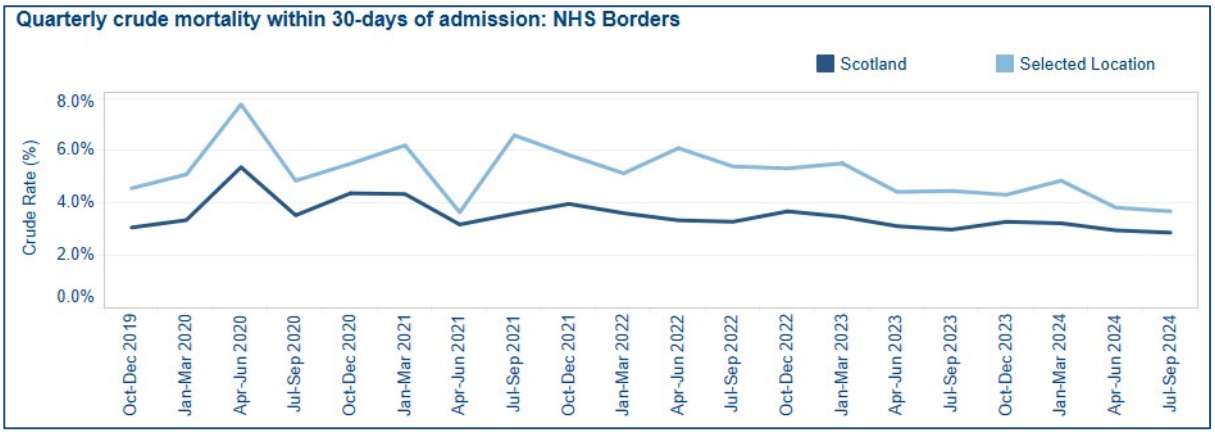


*Figure 8 – NHS Borders Crude Mortality Rate - *Contains deaths in the Margaret Kerr Palliative Care Unit*

2.3.38 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.

2.3.39 Figure 9 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 2 February 2025:

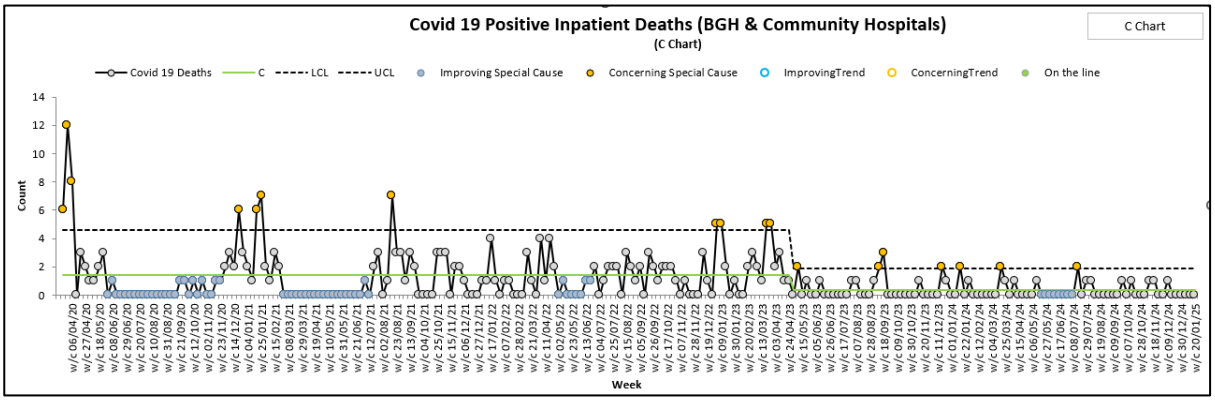


*Figure 9 – Covid 19 Deaths - *From 07/05/2023 patients are counted as Covid positive for 10 days after a positive test. Prior to this, patients were counted as covid positive for 28 days after a positive test.*

2.3.40 Patient Experience

2.3.41 Care Opinion

For the period 1 April 2024 to 28 February 2025 190 new stories were posted about NHS Borders on Care Opinion. Figures 10 and 11 below show the number of stories told in that period and the criticality of these stories. As of 28 February 2025, these 190 stories have been viewed 26,531 times:

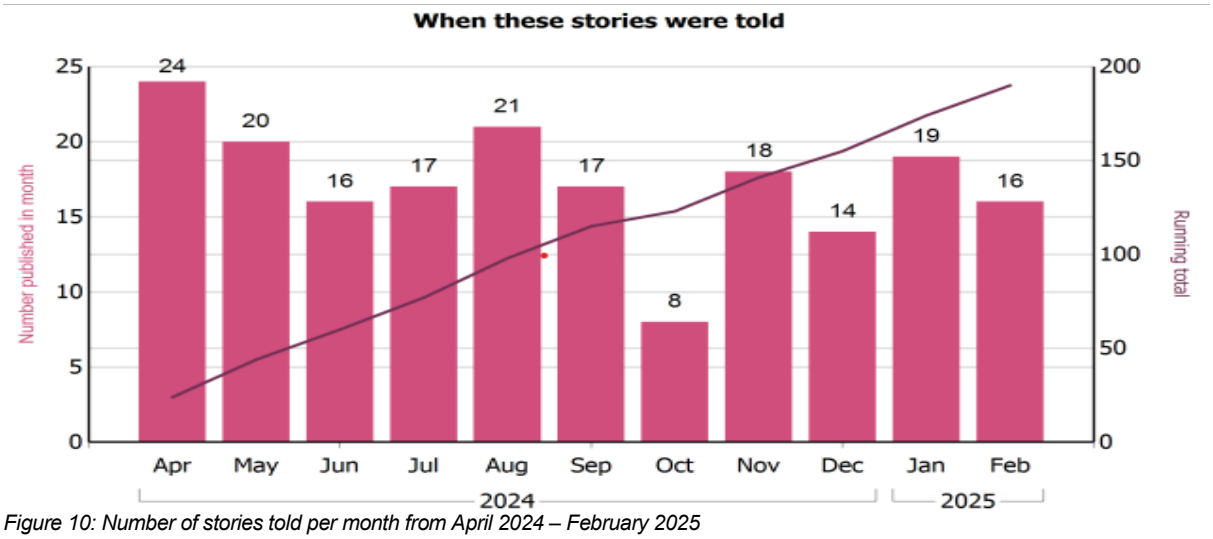


Figure 10: Number of stories told per month from April 2024 – February 2025

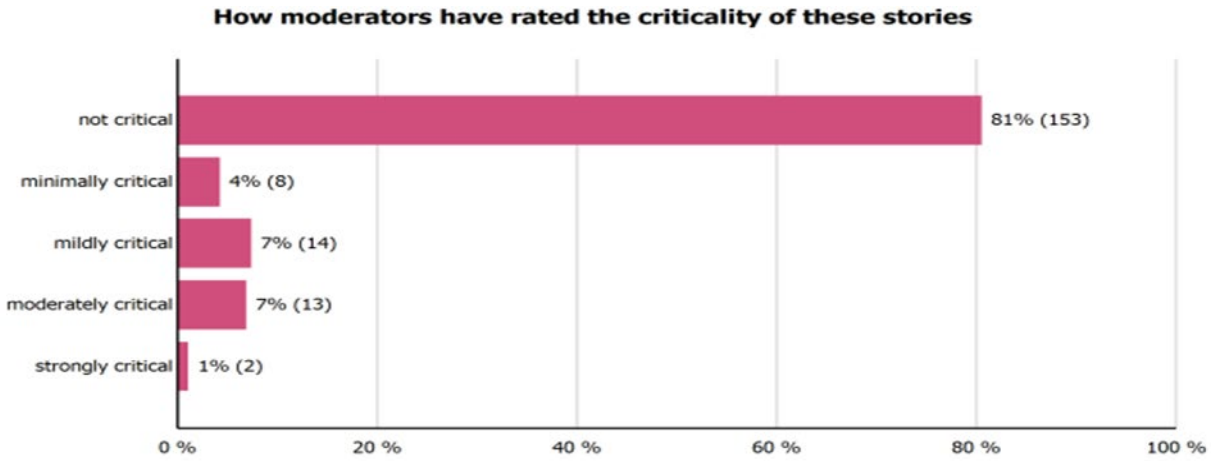


Figure 11 – Criticality of Stories posted between April 2024 – February 2025

2.3.42 The word clouds below summarise ‘what was good’ and ‘what could be improved’ as detailed in Care Opinion posts for this period:

What was good

What could be improved:

2.3.43 Complaints

Figure 12 shows the number of formal complaints received by month across NHS Borders. Whilst there has been a reduction over a six months period demand in the last quarter of 2024/25 has been elevated:

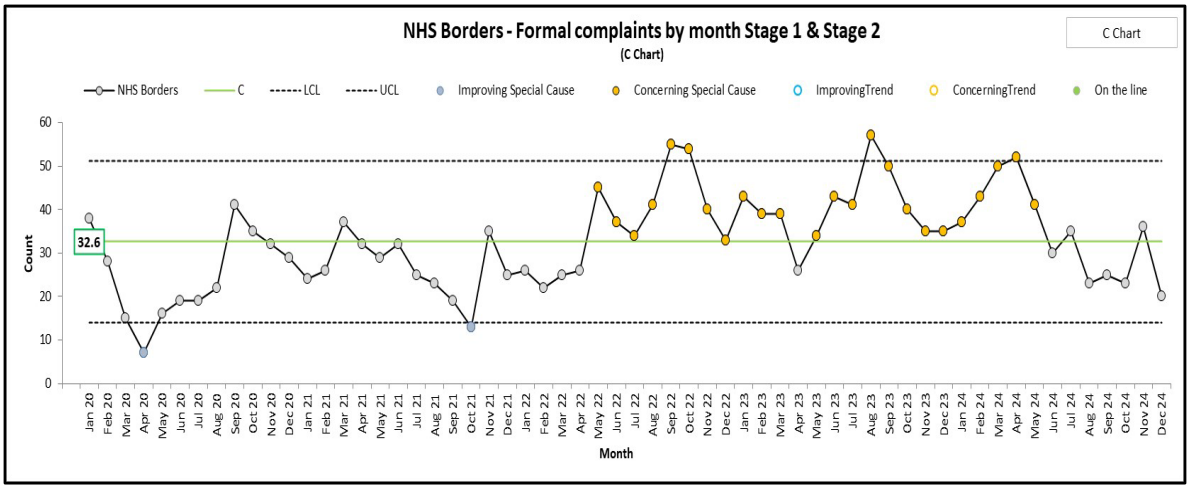


Figure 12 - Complaints by Month NHS Borders

2.3.44 The additional scrutiny provided by the involvement of the Scottish Public Services Ombudsman (SPSO) is welcomed by NHS Borders as this gives a further opportunity to improve both patient care and our complaint handling. Figure 13 shows complaint referrals to the SPSO to December 2024:

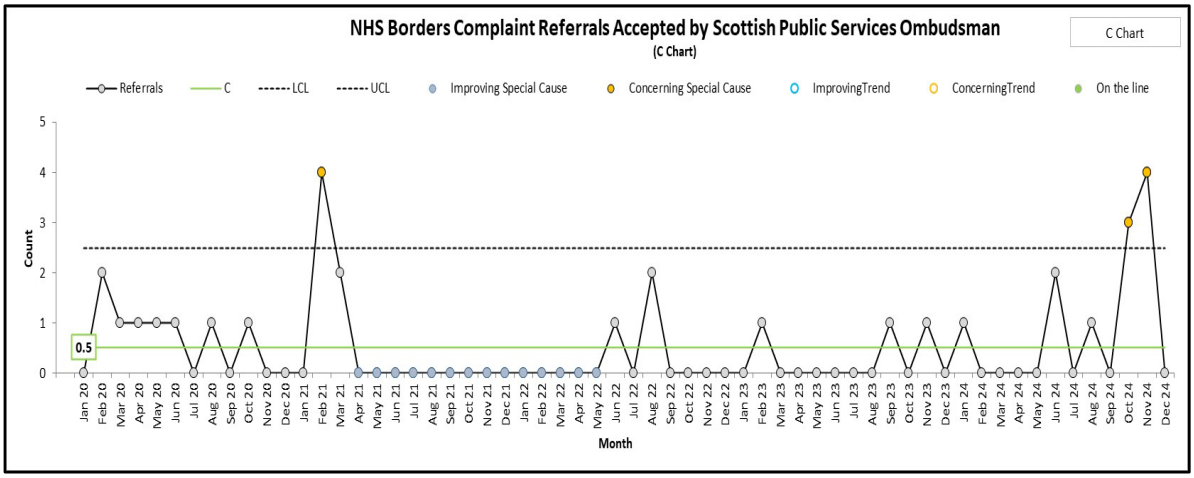


Figure 13 - Complaint referrals to the SPSO to December 2024

2.3.45 COVID Inquiries update

NHS Borders continues to participate in the Scottish Covid-19 Inquiry along with all other Boards in NHS Scotland. The Inquiry will hold hearings investigating the impact of COVID-19 in Scotland on the following themes:

- Worship and Life Events, from 29 April to 2 May 2025
- Equalities and Human Rights, from 10 to 20 June 2025

2.3.46 The impact hearings looking at the theme of Justice took place from 18 to 28 February 2025. Once the Inquiry has completed hearing evidence on the impacts of the pandemic, the Inquiry will begin looking at how policies were implemented in Scotland and the decisions taken by Scottish politicians and their advisers.
All hearings will be broadcast on the Scottish Covid-19 Inquiry's YouTube channel: https://www.youtube.com/@covidinquirysco.

2.3.47 NHS Borders also participates in the UK Covid-19 Inquiry along with all other Boards in NHS Scotland. Public hearings for Module 5 Procurement are scheduled to take place between 3 March and 27 March 2025. Public Hearings for Module 7 Test Trace and Isolate will commence on 12 May 2025, and Module 6 Care Sector on 30 June 2025.

2.3.48 The Chair of the UK Inquiry aims to conclude public hearings in 2026. For each investigation, the Inquiry will produce a report and set of recommendations, which will be published after evidence has concluded. It is planned that the Inquiry's second report, focused on core UK decision-making and political governance (Module 2) will be published in Autumn 2025.

2.3.49 Quality/ Patient Care

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.

2.3.50 Workforce

Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery of waiting times and urgent and unscheduled flow 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. Whilst many services have recovered there are still a number of services which continue to feel the strain of workforce challenges and this needs to remain an area of constant focus for the Board.

2.3.51 Financial

Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery of waiting times and urgent and unscheduled flow 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.

2.3.52 Risk Assessment/Management

Each clinical board is monitoring clinical risk associated with the recovery of elective waiting times and pressure on urgent and unscheduled care services. The NHS Borders risk profile has increased as a result of the extreme pressures across Health and Social Care services.

2.3.53 Equality and Diversity, including health inequalities

An equality impact assessment has not been undertaken for the purposes of this awareness report.

2.3.54 Climate Change

No additional points to note.

2.3.55 Other impacts

No additional points to note.

2.3.56 Communication, involvement, engagement and consultation
This paper is for awareness and assurance purposes and has not followed any consultation or engagement process.

2.3.57 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, based on the level of assurance taken at the clinical governance committee overall a level of **limited assurance** is proposed to the Board.

3 Glossary

Clinical Governance Committee (CGC)
Integrated Joint Board (IJB)
Reinforced Autoclaved Aerated Concrete (RAAC)
Significant Adverse Event (SAER)
Healthcare Acquired Infection (HAI)
Healthcare Improvement Scotland (HIS)
Cardiac Arrest (CA)
Borders General Hospital (BGH)
Occupied Bed Days (OBDs)
Quality Improvement Facilitator (QIF)
Extension for Community Healthcare Outcomes (ECHO)
Multidisciplinary Assessment and Communication (MAC)
Excellence in Care (EiC)
Quality of Care (QoC)
Care Assurance Visits (CAV)
Medical Assessment Unit (MAU)
Hospital Standardised Mortality Ratio (HSMR)
Scottish Public Services Ombudsman (SPSO)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Infection Prevention & Control Report – February 2025**
Responsible Executive/Non-Executive:	**Sarah Horan, Director of Nursing, Midwifery & AHPs**
Report Author:	**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 NHSScotland quality ambition(s):

- Safe

2 Report summary

2.1 Situation

This report provides an overview for NHS Borders Board of infection prevention and control with particular 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. Key Healthcare Associated Infection Headlines

- ***Staphylococcus aureus* Bacteraemia (SAB)**

1.1 NHS Borders had a total of 34 *Staphylococcus aureus* bacteraemia (SAB) cases between April and December 2024, 18 of which were healthcare associated infections.

1.2 The Scottish Government previously 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).

1.3 We are awaiting updated Scottish Government targets for 2024/25. Until then, we will continue to use our 2023/24 target which equates to no more than 20 healthcare associated SAB cases. We are not on target to achieve this as shown in figure 1 below

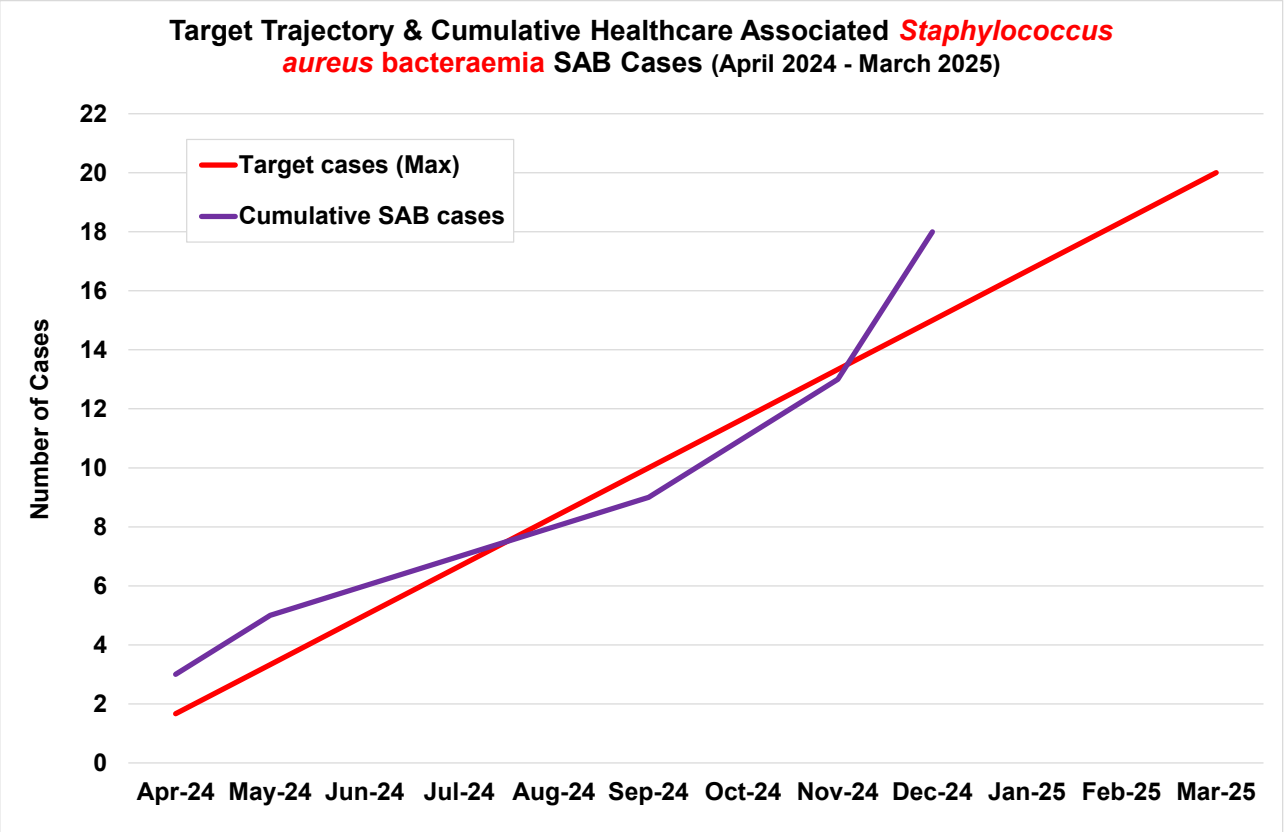


Figure 1: SAB Scottish Government target trajectory and cumulative NHS Borders healthcare associated SAB Cases

- ***Clostridioides difficile* Infection (CDI)**

1.4 NHS Borders had a total of 16 *C. difficile* Infection (CDI) cases between April and December 2024; 9 of which were healthcare associated infections.

1.5 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).

1.6 We are awaiting updated Scottish Government targets for 2024/25. Until then, we will continue to use our 2023/24 target which equates to no more than 12 healthcare associated CDI cases. We are currently on target to achieve this as shown in figure 2 below.

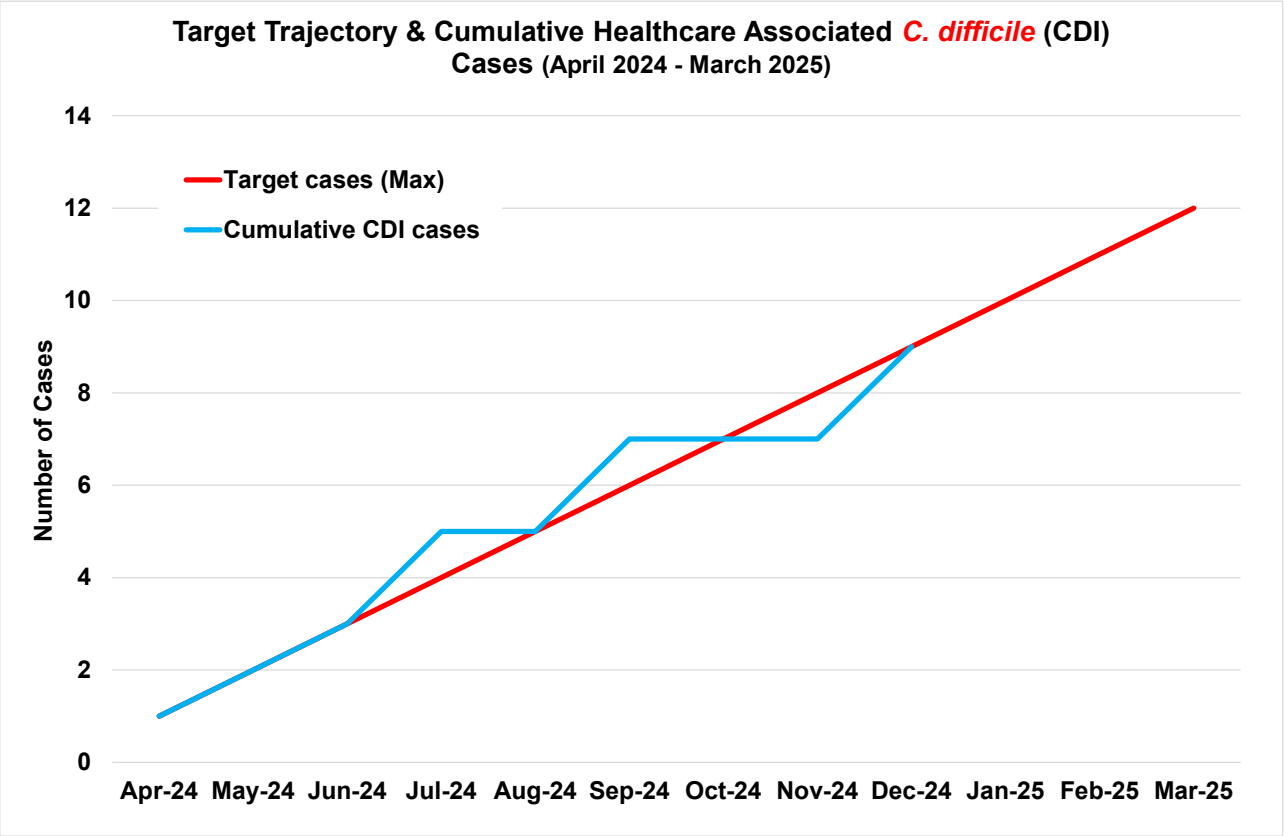


Figure 2: Scottish Government target trajectory and cumulative NHS Borders healthcare associated CDI cases

- ***Escherichia coli* bacteraemia (ECB)**

1.7 NHS Borders had a total of 94 *Escherichia coli* bacteraemia (ECB) cases between April and December 2024; 41 of which were healthcare associated infections.

1.8 The Scottish Government previously 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).

1.9 Our target for 2023/24 equated to no more than 32 healthcare associated ECB cases. We are awaiting updated Scottish Government targets for 2024/25. Until then, we will continue to use our 2023/24 target as illustrated in Figure 3 below. We have not achieved this target.

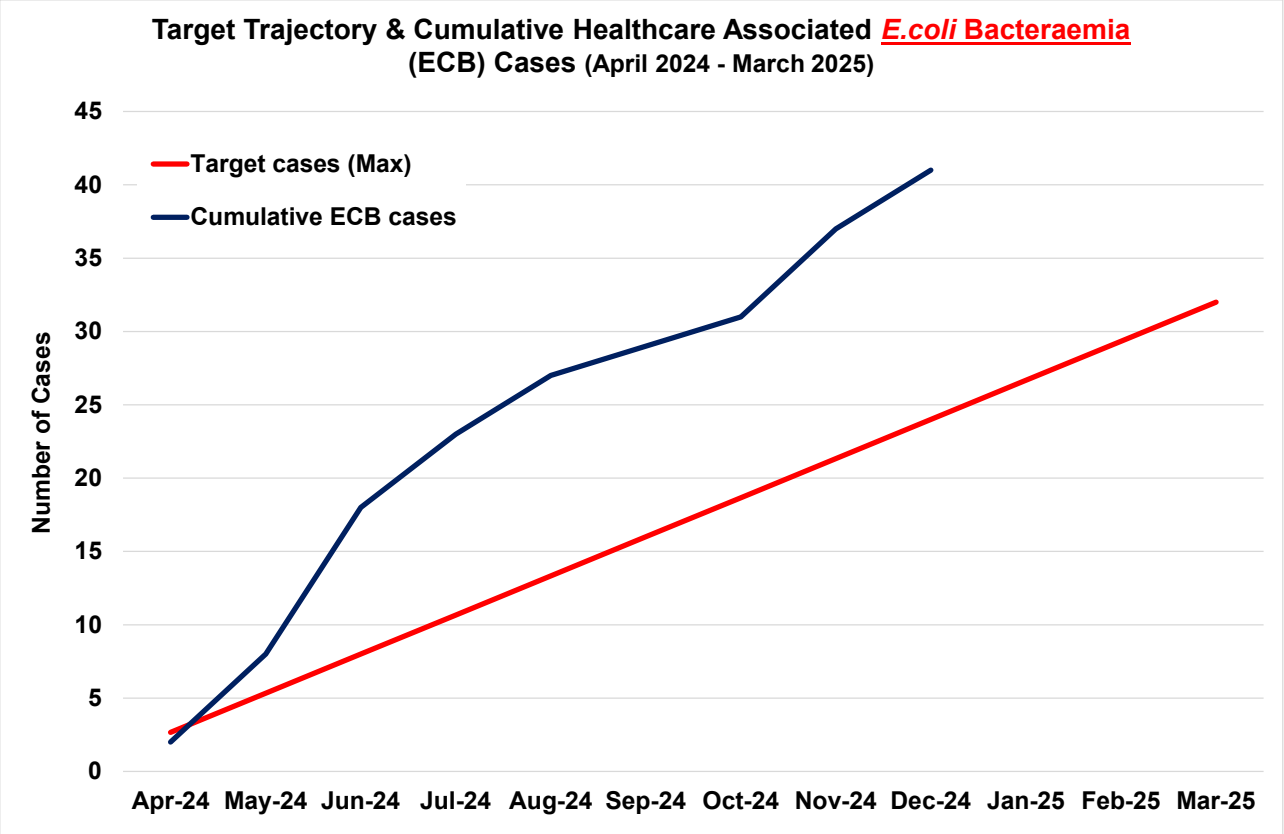


Figure 3: Scottish Government target trajectory and cumulative NHS Borders healthcare associated ECB Cases

2. Infection Surveillance

- ***Staphylococcus aureus* Bacteraemia (SAB)**
  (Background information provided in Appendix A)

2.1 Between April and December 2024, there have been 33 cases of Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and 1 case of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia.

2.2 Figure 4 shows a Statistical Process Control (SPC) chart showing the number of Healthcare Associated SAB cases per month.

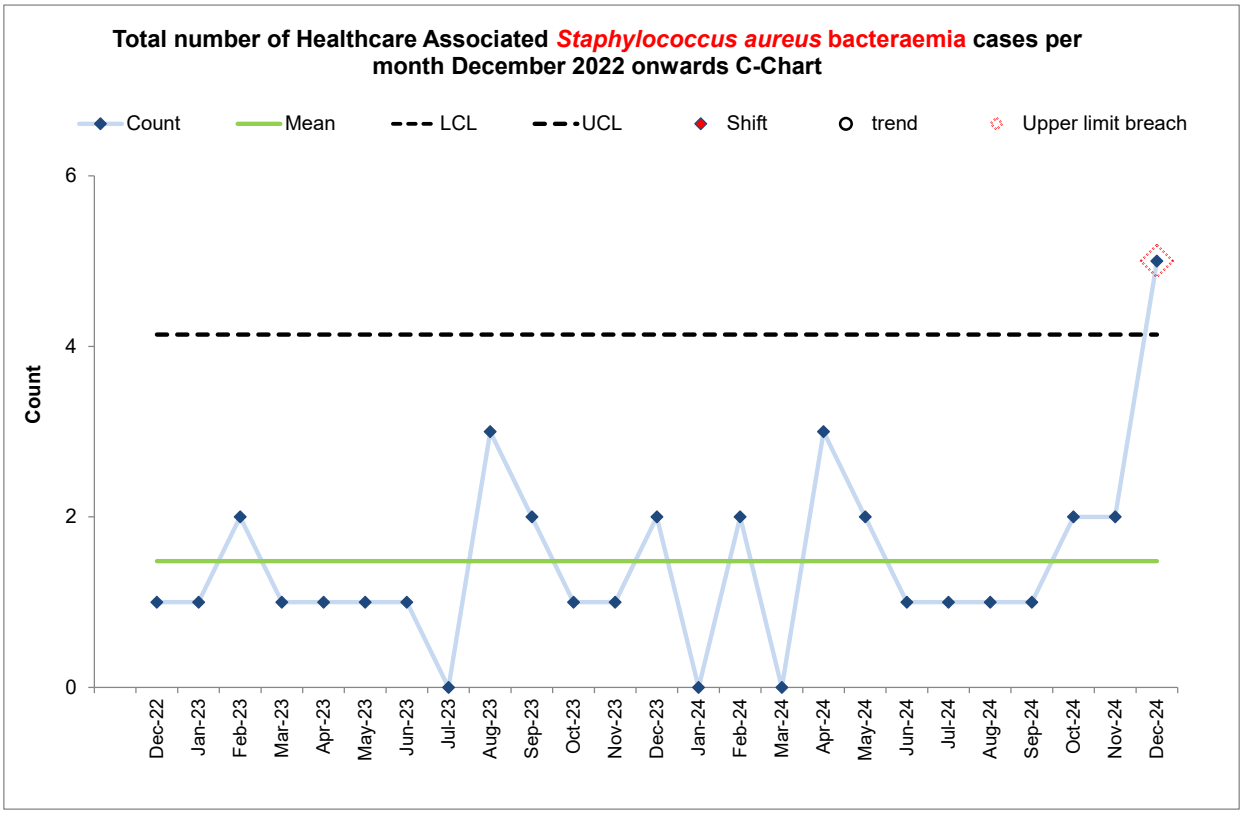


Figure 4: Statistical Process Control 'C' Chart showing number of Healthcare Associated SAB cases per month

2.3 In December 2024, there were 5 cases which was a statistically significantly increase. Two of the cases were associated with skin / soft tissue. This reflects a shift over the last 12 months with this now being the most frequent cause of healthcare associated SAB cases rather than Catheter Associated Urinary Tract Infection (CAUTI). This is shown as a Pareto Graph in Figure 5 below.

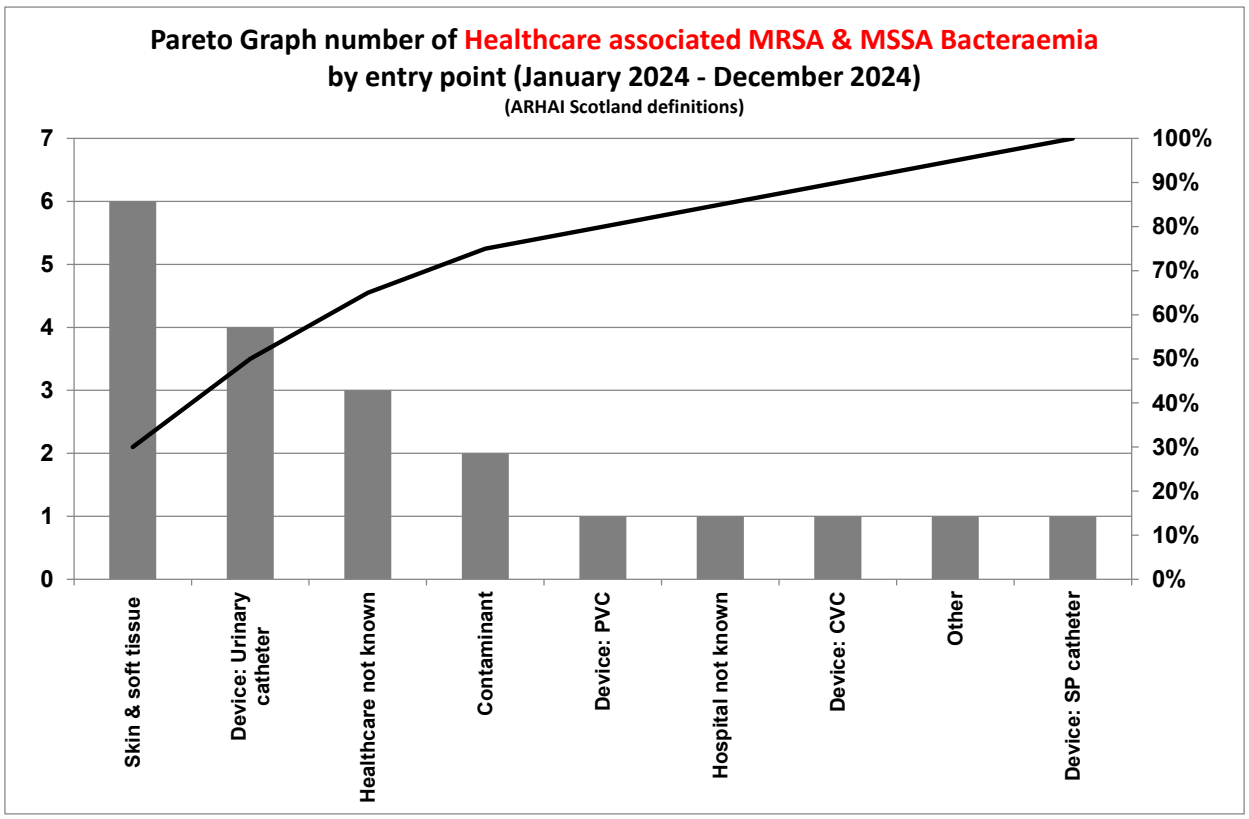


Figure 5: Pareto chart of NHS Borders healthcare associated SAB cases by entry point

2.4 Further analysis of the skin / soft tissue cases is shown in Figure 6 below. Four of the cases were associated with diabetic foot ulcers. The patients were seen by different staff in different community locations. The SAB laboratory isolates get typed by the reference lab routinely and all of these episodes were caused by different strains so there is no evidenced of cross transmission.

2.5 The Consultant Microbiologist is arranging to meet with a lead Podiatrist and Consultant Physician to review the cases and consider any learning.

2.6 At the most recent meeting of Prevention of CAUTI group, a process was agreed for all future CAUTI cases to be subject to a review by the relevant clinical lead with learning fed back to the Group.

2.7 The Infection Prevention and Control Team is in the process of revising surveillance and learning processes. This includes shortening the timescale to review SAB cases. With immediate effect, this enables any learning from SAB cases associated with peripheral or central venous cannula (PVC, CVC) to be fed back to the relevant clinical lead more rapidly - before the patient is discharged.

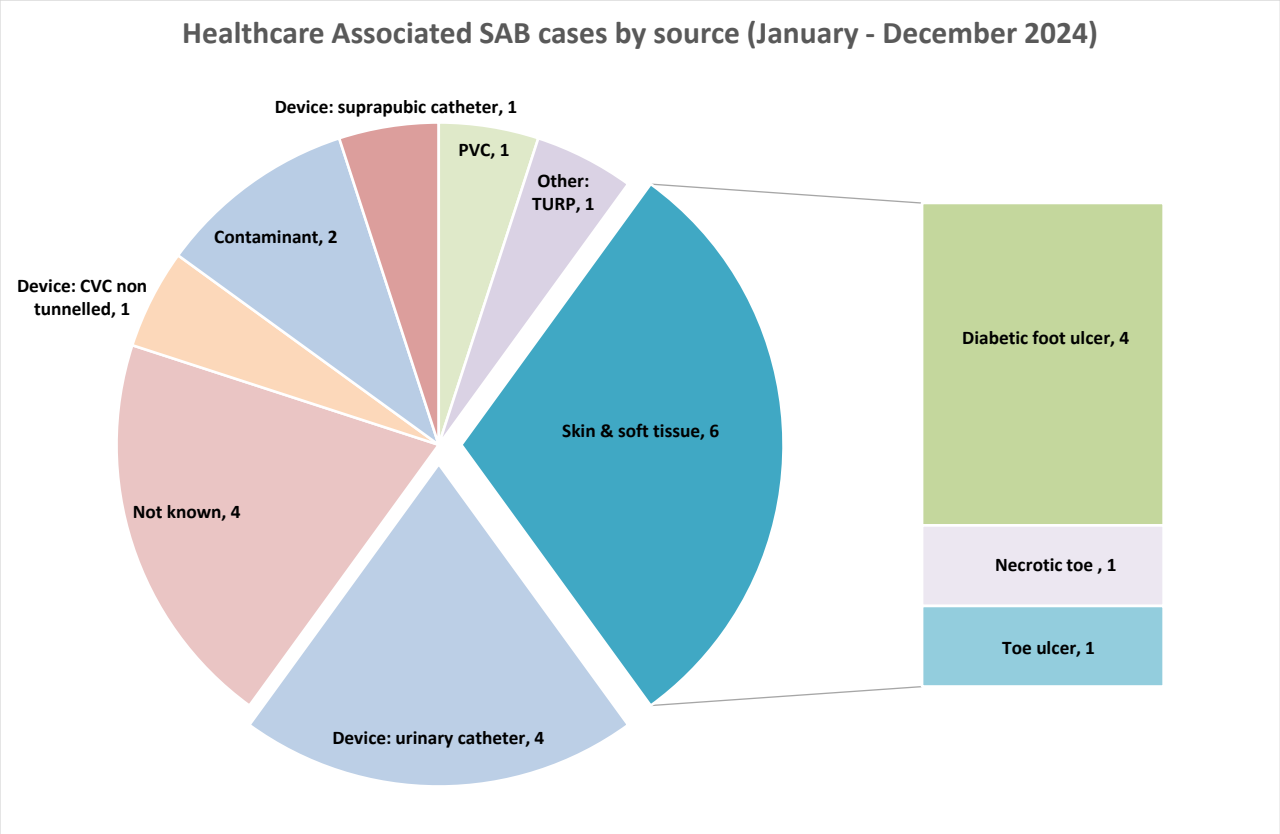


Figure 6: Pie chart of Healthcare Associated SAB cases by source (January to December 2024)

- ***Clostridioides difficile* Infection (CDI)**

2.8 Figure 7 below shows a Statistical Process Control (SPC) chart showing the number of days between each healthcare associated CDI case. The reason for displaying the data in this type of chart is due to CDI cases being rare events with low numbers each month. These charts highlight any statistically significant events which are not part of the natural variation within our health system.

2.9 In interpreting Figure 7, 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.

2.10 The graph shows that there have been no statistically significant events since the last update.

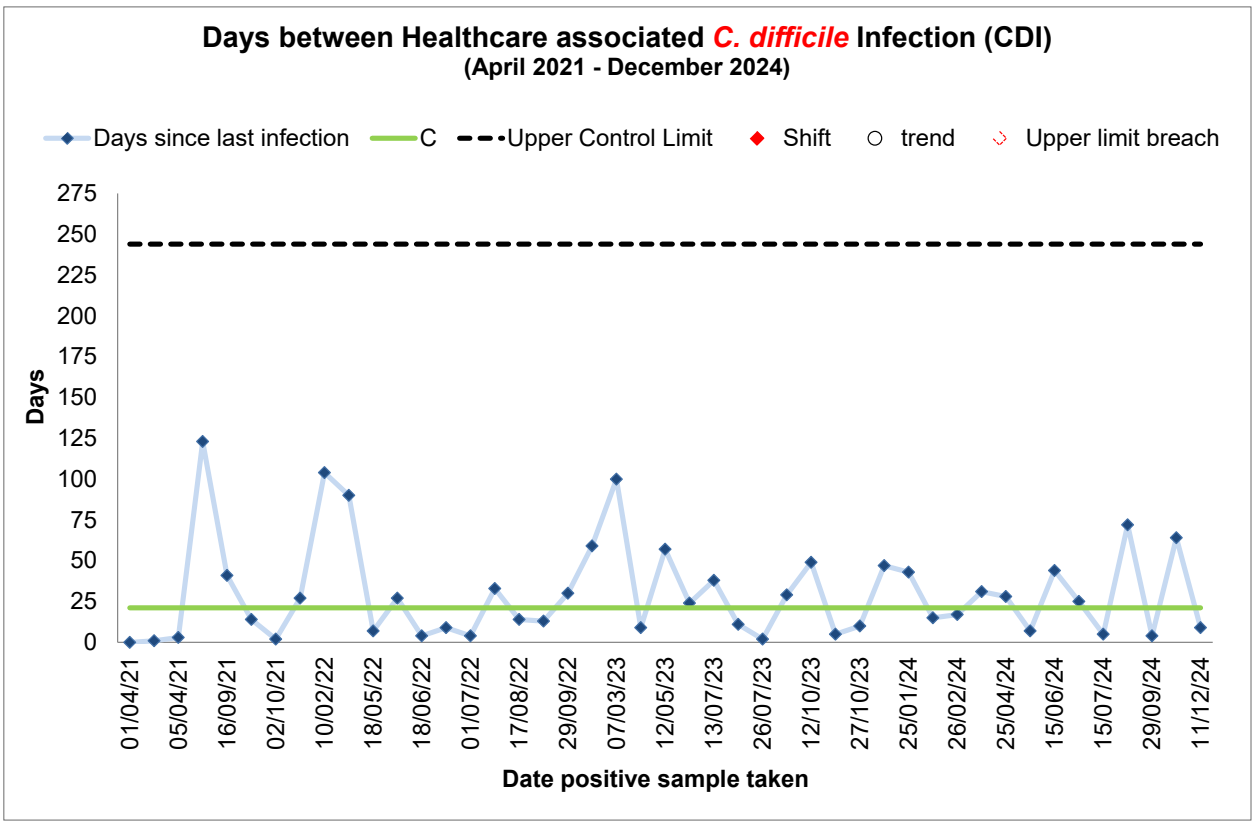


Figure 7: Days between healthcare associated CDI cases

- ***Escherichia coli* bacteraemia (ECB)**

2.11 The primary cause of preventable healthcare associated ECB cases is Catheter Associated Urinary Tract Infection (CAUTI) as shown in Figure 8 below.

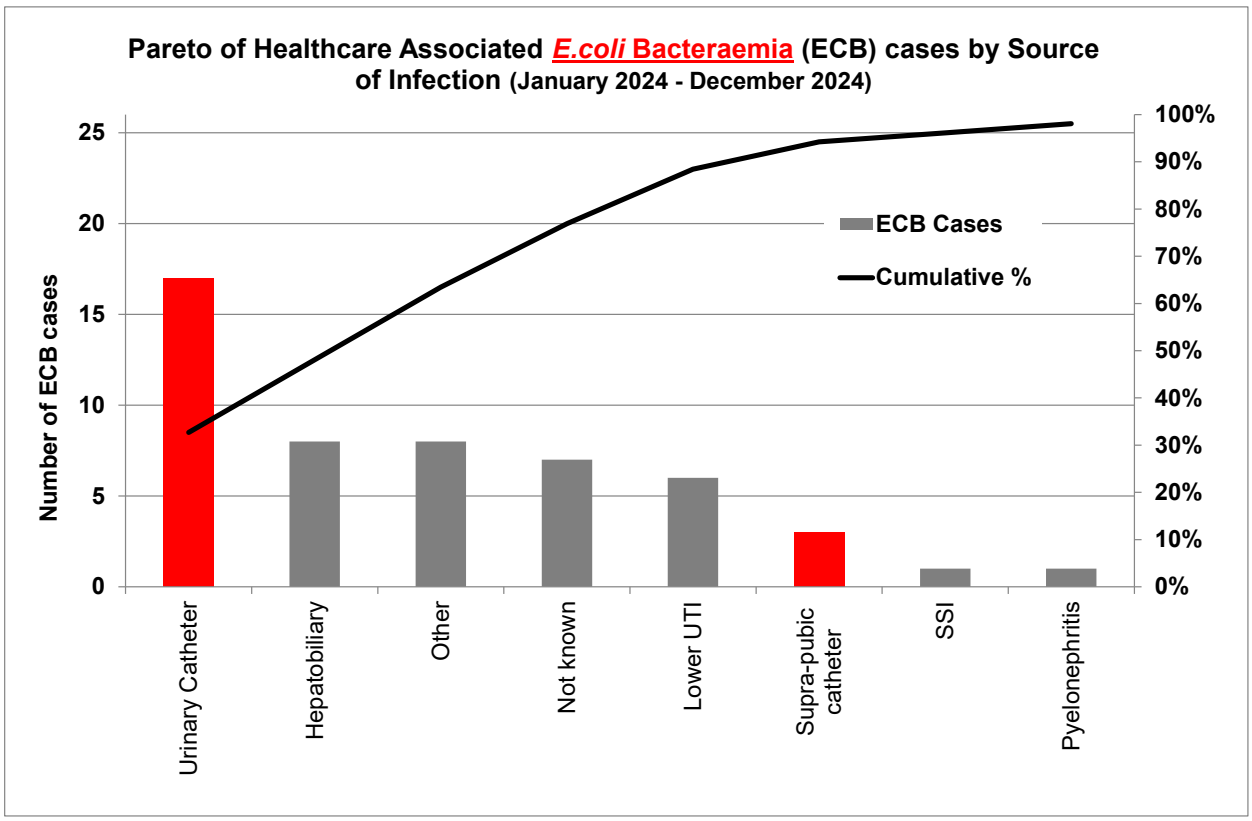


Figure 8: Pareto chart of healthcare associated ECB cases by source of infection

2.12 Figure 9 shows a statistical process chart of the total number of healthcare associated *E.coli* bacteraemia cases per month. The chart shows that there has not been a statistically significant increase in cases since the last update paper.

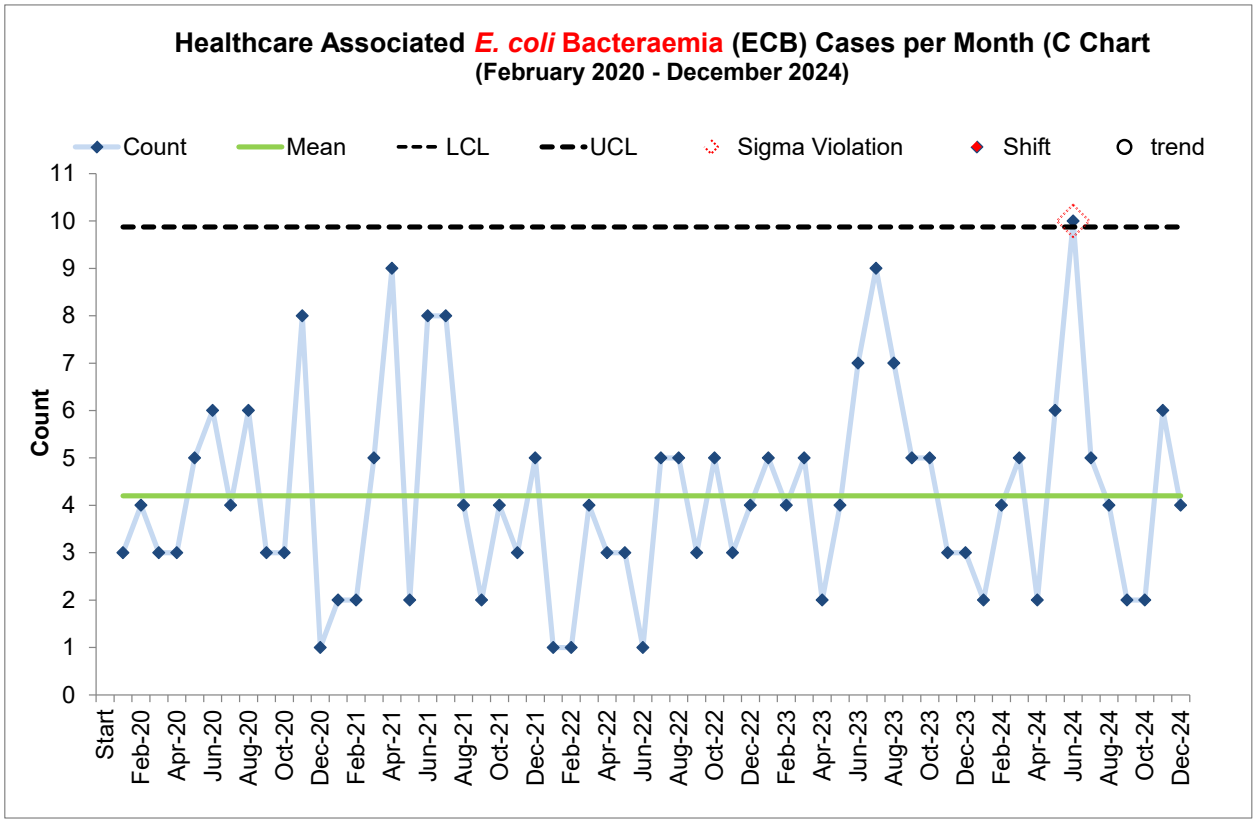


Figure 9: Statistical process chart (SPC) of healthcare associated *E.coli* bacteraemia cases per month

- **Surgical Site Infection (SSI) Surveillance**

2.13 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.

2.14 Up to date SSI surveillance is not currently available. This is partly due to a backlog of work associated with the vacant posts of HAI Surveillance Lead and Infection Control Support Assistant. In addition, it has become apparent that the process of reviewing potential SSI cases by clinical services needs to be more robust. A recent deep-dive into the 2023 knee and hip arthroplasty SSI cases identified that three of the cases previously reported have now been discounted as they did not meet the definitions in the national guidance.

2.15 The table below shows the data previously reported to NHS Borders Board alongside the updated data following the deep-dive review of 2023 cases.

Summary of Hip & Knee Surgical Site Infection (SSI) cases (Using ARHAI Scotland definitions) **(January - December 2023)**					
		PREVIOUS DATA		**REVISED DATA**	
Procedure	**Total ops**	**Total SSIs**	**SSI Rate**	**Total SSIs**	**SSI Rate**
Hip arthroplasty	255	6	2.35%	4	1.57%
Knee arthroplasty	136	4	2.94%	3	2.21%

2.16 A detailed review of the SSI cases in 2024 is currently progressing. The outcome of this will be included in the next update to the Board. The Infection Control Manager is arranging to meet with Clinical Service Leads about the need to review surveillance processes and establish real-time reporting of robust data.

2.17 A further update on the improvement activity being progressed by the Orthopaedic SSI Task and Finish Group is scheduled for the next meeting of the Infection Control Committee.

3. Incidents and Outbreaks

- **Outbreaks**

3.1 Since the last Board meeting, there have been 10 respiratory clusters and 4 gastrointestinal clusters. A summary for each cluster as at 26th February 2025 is detailed in Appendix B.

3.2 Learning from each incident is captured and acted upon in real time where appropriate.

3.3 In December 2024, there were two instances where BGH site pressures required assessment and prioritisation across a range of clinical risks. This resulted in patient placement decisions which increased infection transmission risk. The Infection Control Manager has had an initial meeting with the Deputy Hospital Manager for Acute and Unscheduled Care to discuss how decisions such as this are taken and recorded. A further meeting is scheduled to develop a process for ensuring the right

accountable healthcare providers are making the risk assessment and that the outcome is documented.

3.4 In January 2025, two patients in the Borders Specialist Dementia Unit (BSDU) had Group A streptococcal (GAS) isolated from clinical samples. Laboratory typing confirmed that the organisms were indistinguishable from each other and also from previous cases in May 2024. An Incident Management Team was convened to investigate further and oversee implementation of control measures.

4. Infection Control Compliance Monitoring Programme

4.1 In December 2024 and January 2025, spot checks were undertaken in 14 clinical areas. Themes identified from spot checks during 2024/25 are:

- High dust
- Staff observed using PPE incorrectly
- Staff not compliant with 5 moments of hand hygiene
- Sharps bins temporary closures not in place
- Contaminated equipment including commodes

4.2 These themes will inform the content of staff education updates.

4.3 The IPC audit programme for 2024/25 was completed by November 2024. A new audit programme commenced in March 2025.

5. Quality Improvement Update

- **Hand Hygiene**

5.1 Hand hygiene audits were undertaken in 10 areas during January 2025 with an overall compliance of 65%**.** The most recent audit data is shown in Appendix C which includes line graphs of compliance for nursing and medical staff.

5.2 Analysis of compliance by World Health Organisation (WHO) Moments for Hand Hygiene (Appendix C) shows compliance with Moment 4 (after touching a patient) is much higher than Moment 1 (before touching a patient). This could be due to perception of risk with staff recognising the risk to them from the patient but not the risk they pose to the patient.

5.3 Individual data summaries have been developed and distributed to each clinical area to enable all staff to be aware of the audit outcomes where they work.

5.4 In February 2024, rapid education sessions are being delivered in clinical areas. The training specifically addresses the different perception of risk indicated by the audit results and explains the practical application of the 5 moments of hand hygiene. Further audits will commence at the end of March 2025.

- **Catheter Associated Urinary Tract Infection (CAUTI)**

5.5 At the most recent meeting, the Prevention of CAUTI Group was informed of some examples of poor catheter practice associated with lack of communication at points of transition of care. The Group was also informed of examples of deviation from NHS Borders Catheter Policy.

5.6 The Group recognised that the current approach to relying on a patient-held record (catheter passport) has resulted in

- Unclear consistency in the distribution and use of the patient-held record
- Lack of assurance that catheters are used for the correct reasons
- Lack of assurance that catheters are removed when they should be

5.7 The Chair of the Prevention of CAUTI Group is drafting a SBAR to be presented to each of the Clinical Board Governance Groups with a recommendation to establish a Short-life Working Group to address these issues.

5.8 Further updates on the work of the Prevention of CAUTI Group will be provided in future updates to the Clinical Governance Committee.

6 Infection Control Work Plan 2024/25

6.1 The posts of HAI Surveillance Lead and Infection Control Support Assistant are currently vacant and this is impacting on Team capacity. In addition, significant Infection Prevention Control Team capacity is currently supporting legal processes.

6.2 Both vacant posts have been approved for external recruitment and this is progressing.

6.3 There are currently eight overdue actions in the 2024/25 Infection Control Work Plan of which two are assessed as medium risk and the remainder are low risk.

7. 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 October – December 2024. Figure 10 below shows the cleanliness score for this period was 95%. In the same period, the estates score was 98.2%.

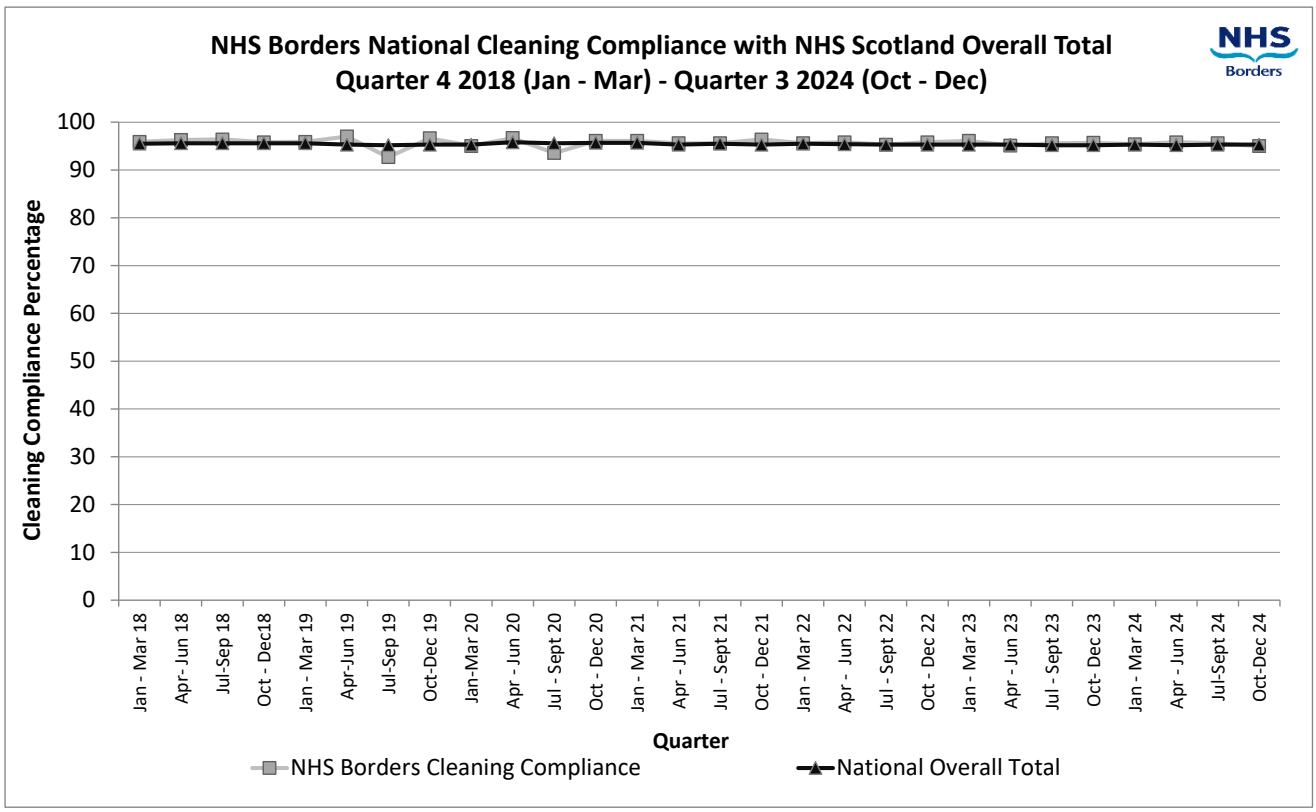


Figure 10: NHS Borders cleaning compliance against the NHS Scotland average by quarter

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information, for each acute hospital and key community hospitals in the Board, on the number of cases of Staphylococcus aureus blood stream infections (also broken down into MSSA and MRSA) and Clostridium difficile infections, as well as cleaning compliance. In addition, there is a single report card which covers all community hospitals [which do not have individual cards], and a report which covers infections identified as having been contracted from out with hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridium difficile infections (CDI) and Staphylococcus aureus bacteraemia (SAB) cases are presented for each hospital, broken down by month. Staphylococcus aureus bacteraemia (SAB) cases are further broken down into Meticillin Sensitive Staphylococcus aureus (MSSA) and Meticillin Resistant Staphylococcus aureus (MRSA).

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

Targets

There are national targets associated with reductions in E.coli bacteraemia, C.diff and SABs. More information on these can be found on the UKHSA website:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1081256/mandatory-healthcare-associated-infection-surveillance-data-quality-statement-FY2019-to-FY2020.pdf

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website:
http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Understanding the Report Cards – '*Out of Hospital Infections*'

Clostridium difficile infections and Staphylococcus aureus (including MRSA) bacteraemia cases are associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes. The final Report Card report in this section covers 'Out of Hospital Infections' and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

NHS BORDERS BOARD REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
MRSA	0	0	0	0	0	0	0	0	0	1	0	0
MSSA	2	5	1	5	3	2	2	4	2	3	4	8
Total SABS	2	5	1	5	3	2	2	4	2	4	4	8

Clostridioides difficile infection monthly case numbers

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Ages 15-64	0	0	0	1	0	0	2	0	0	0	0	0
Ages 65 plus	1	2	1	1	1	1	2	1	3	1	0	2
Ages 15 plus	1	2	1	2	1	1	4	1	3	1	0	2

Cleaning Compliance (%)

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Board Total	96.4	95.1	96.1	95.2	95.9	96.3	96.0	96.0	95.5	95	95.6	95.4

Estates Monitoring Compliance (%)

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Board Total	97.9	95.4	98.6	98.7	98.5	98.6	97.1	98.1	98.5	97.5	98.6	98.5

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	1	0	2	0	1	1	0	1	0	1	3
Total SABS	0	1	0	2	0	1	1	0	1	0	1	3

Clostridioides difficile infection monthly case numbers

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	1	2	1	0	0	1	0	0	1	0	0	2
Ages 15 plus	1	2	1	0	0	1	0	0	1	0	0	2

Cleaning Compliance (%)

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
BGH Total	98.4	98.0	98.3	95.2	95.1	95.5	95.6	95.5	94.1	95	95	94.5

Estates Monitoring Compliance (%)

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
BGH Total	98.3	99.0	98.1	98.7	98.3	98.5	98.3	98.3	98.4	97.9	98.8	98.3

NHS COMMUNITY HOSPITALS REPORT CARD

The community hospitals covered in this report card include:

- **Haylodge Community Hospital**
- **Hawick Community Hospital**
- **Kelso Community Hospital**
- **Knoll Community Hospital**

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0
Total SABS	0	0	0	0	0	0	0	0	0	0	0	0

Clostridioides difficile infection monthly case numbers

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	0	0	0	0	0
Ages 15 plus	0	0	0	0	0	0	0	0	0	0	0	0

NHS OUT OF HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
MRSA	0	0	0	0	0	0	0	0	0	1	0	0
MSSA	2	4	1	3	3	1	1	4	1	3	3	5
Total SABS	2	4	1	0	3	1	1	4	1	4	3	5

Clostridioides difficile infection monthly case numbers

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Ages 15-64	0	0	0	1	0	0	2	0	0	0	0	0
Ages 65 plus	0	0	0	1	1	0	2	1	2	1	0	0
Ages 15 plus	0	0	0	2	1	0	4	1	2	1	0	0

2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety.

2.3.2 Workforce

Infection Control staffing issues are detailed in this report.

2.3.3 Financial

The paper refers to a Scottish Government expectation to fully implement new water safety guidance by 1st January 2025. The implementation cost has not been assessed and national discussions reflecting concerns with the guidance continue.

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. Much of the data was included in the monthly infection control report 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 has been presented to the Clinical Governance Committee.

2.4 Recommendation

Board 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:

- **Moderate Assurance**

3 List of appendices

The following appendices are included with this report:

Appendix A: Supplementary information and definitions
Appendix B: Outbreak summary
Appendix C: Infection Control - Internal Audit action plan progress
Appendix D: Hand Hygiene Audit summary

APPENDIX A

Definitions and Supplementary Information

Staphylococcus aureus Bacteraemia (SAB)

Staphylococcus aureus is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is Meticillin Sensitive *Staphylococcus Aureus* (MSSA), but the more well-known is MRSA (Meticillin Resistant *Staphylococcus Aureus*), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat. More information on these organisms can be found at:

Staphylococcus aureus : https://www.nhs.uk/conditions/staphylococcal-infections/

MRSA: https://www.nhs.uk/conditions/mrsa/

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemia. These are a serious form of infection and there is a national target to reduce them. The number of patients with MSSA and MRSA bacteraemia for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemia can be found at:

https://www.hps.scot.nhs.uk/publications/?topic=HAI%20Quarterly%20Epidemiological%20Data

Clostridioides difficile infection (CDI)

Clostridioides difficile is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at:

http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx

NHS Boards carry out surveillance of *Clostridioides difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridioides difficile* infections can be found at:

https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/#data

Escherichia coli bacteraemia (ECB)

Escherichia coli (*E. coli*) is a bacterium that forms part of the normal gut flora that helps human digestion. Although most types of *E. coli* live harmlessly in your gut, some types can make you unwell. When it gets into your blood stream, *E. coli* can cause a bacteraemia. Further information is available here:

https://www.gov.uk/government/collections/escherichia-coli-e-coli-guidance-data-and-analysis

NHS Borders participate in the HPS mandatory surveillance programme for ECB. This surveillance supports local and national improvement strategies to reduce these infections and improve the outcomes for those affected. Further information on the surveillance programme can be found here: https://www.hps.scot.nhs.uk/a-to-z-of-topics/escherichia-coli-bacteraemia-surveillance/

Hand Hygiene

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.

Cleaning and the Healthcare Environment

Keeping the healthcare environment clean is essential to prevent the spread of infections. NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%. The cleaning compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national cleanliness compliance monitoring can be found at:

http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Healthcare environment standards are also independently inspected by Healthcare Improvement Scotland. More details can be found at:

https://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services.aspx

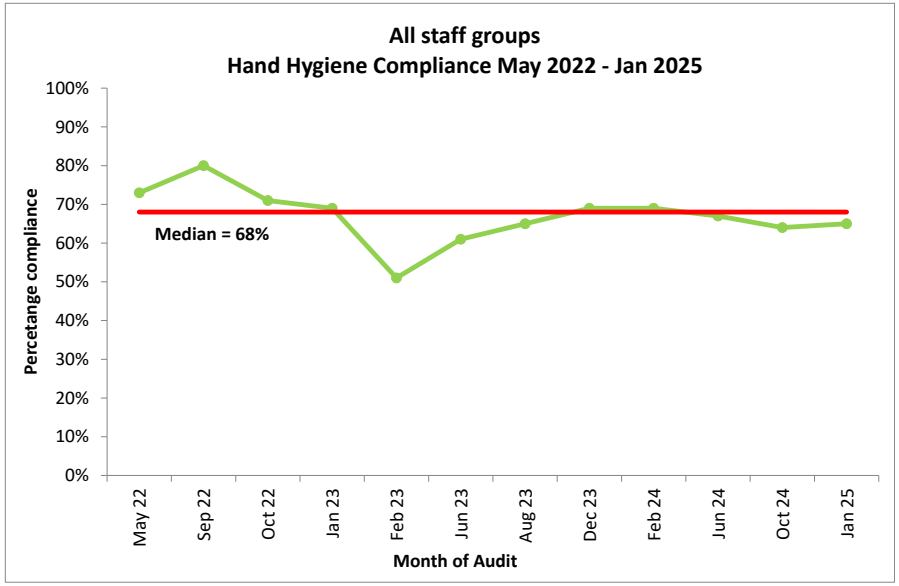
Appendix B

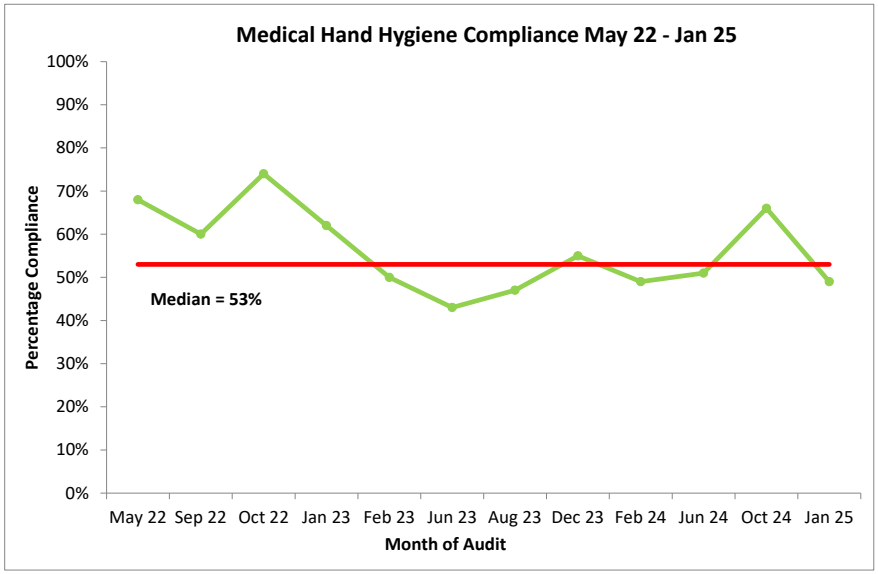
NHS Borders Respiratory and Gastrointestinal Outbreak Summary

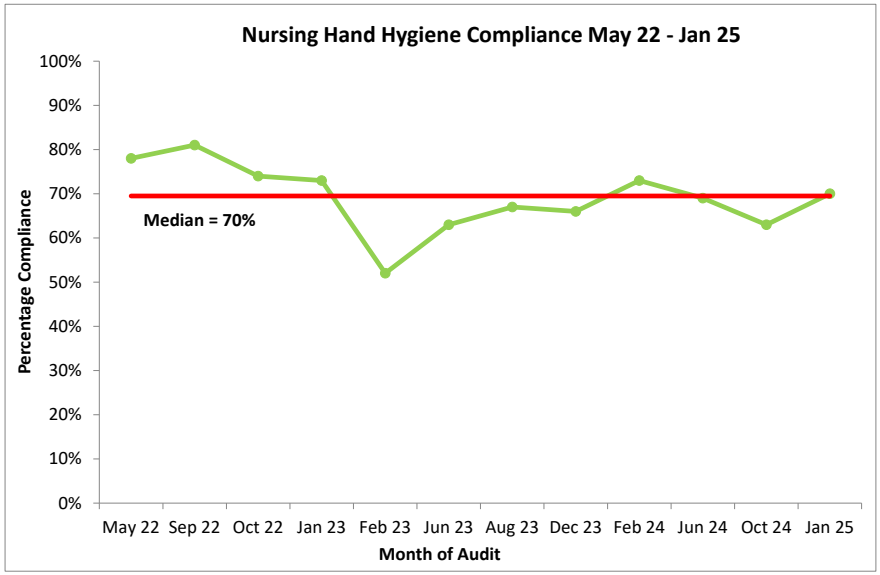
NHS Borders Clusters as at 26/02/2025 (CLOSED INCIDENTS ONLY)					
Outbreak start date	**Outbreak location(s)**	**Organism**	**Positive patient cases**	**Patient deaths**	**Suspected/ confirmed staff cases**
14/12/2024	Ward 4	Norovirus	6	0	0
24/12/2024	Ward 5	Flu	2	0	0
25/12/2024	Border View	Flu	10	0	6
30/12/2024	Ward 9	Norovirus	2	0	0
30/12/2024	MAU	Norovirus	4	0	0
03/01/2025	Hawick	RSV	6	0	1
04/01/2025	DME 14	Norovirus	9	1	0
06/01/2025	Ward 4	Flu	4	0	1
14/01/2025	MAU	Flu	4	0	0
18/01/2025	DME 14	Flu	2	0	0
20/01/2025	Kelso	COVID	10	0	10
20/01/2025	BSDU	RSV	4	0	0
02/02/2025	MAU	Flu	5	0	0
05/02/2025	Ward 4	Flu	4	0	0

Hand Hygiene Audit Summary by staff group

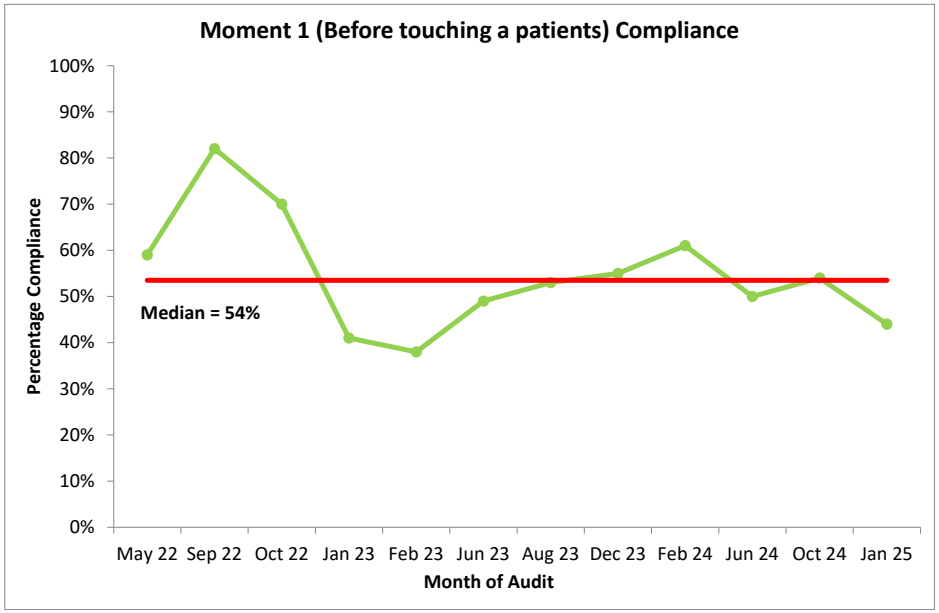
Appendix C

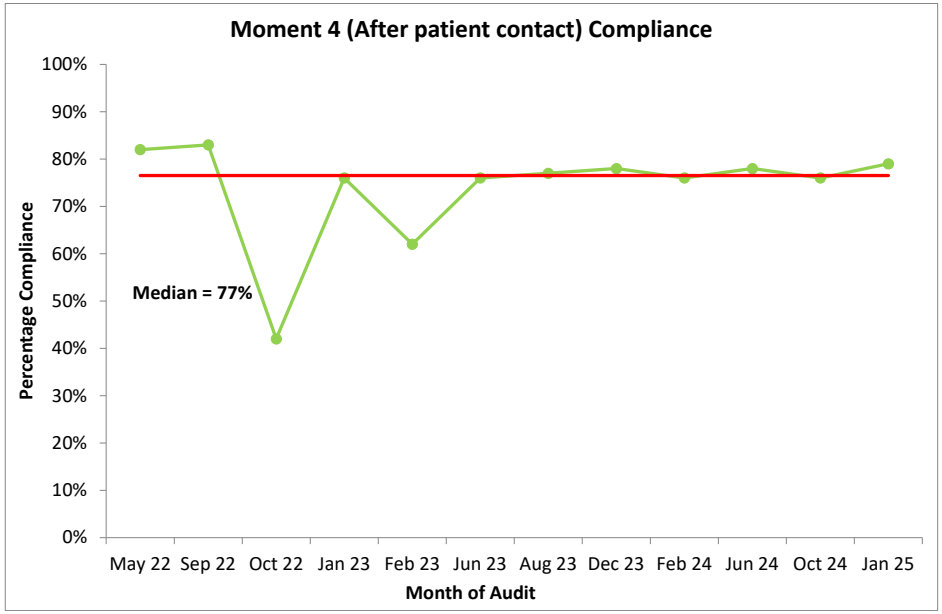






Hand Hygiene Compliance by World Health Organisation (WHO) key moment for Hand Hygiene





NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**Equalities Mainstreaming Report 2025**
Responsible Executive/Non-Executive:	**Dr Sohail Bhatti**
Report Author:	**Dr Sohail Bhatti**

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

NHS Borders has a duty to produce a 4 yearly Equalities Mainstreaming Report under the Equality Act (2010) (and specific sections therein).

Specific protection is provided for people who fall under the nine protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity

- Race
- Religion or belief
- Rex
- Sexual orientation

Within the Act, the Public Sector General Equality Duties are:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act.
2. Advance equality of opportunity between persons who share a relevant characteristic and persons who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

The Fairer Scotland Duty, Part 1 of the Equality Act (2010) holds public bodies in Scotland legally responsible for taking into consideration ways in which inequalities caused by socioeconomic disadvantage can be reduced.

To meet the obligations of the Duty, public bodies must achieve the key requirements:

1. To actively consider how they could reduce inequalities of outcome in any major strategic decision they make
2. To publish a written assessment, showing how they've done this

The last full report was published in 2021, and a progress report was produced in 2023. The current report will require a progress report in 2027. The final section includes areas for further action, and the 2027 update will need to focus on these.

2.2 Background

Mainstreaming is a long-term method which ensures decisions made take into account the diverse requirements of all who access services delivered by NHS Borders i.e. patients, families, staff, our communities. This transparent report provides evidence and information about how NHS Borders are embedding Mainstreaming into our decision-making processes.

2.3 Assessment

Our eight reporting outcomes are:

1. We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected, and our workforce reflects our community.
2. Our services meet the needs of and are accessible to all members of our community.
3. Our staff treat all service users, clients and colleagues with dignity and respect.
4. We work in partnership with other agencies and stakeholders to ensure everyone has the opportunity to participate in public life and the democratic process.
5. We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the health inequality gap is reduced.
6. We work in partnership with other agencies and stakeholders to ensure the difference in rates of employment between the general population and those from underrepresented groups is improved.
7. We work in partnership with other agencies and stakeholders to ensure the difference in educational attainment between those who are from an equality group and those who are not is improved.
8. We work in partnership with other agencies and stakeholders to ensure we have appropriate housing which meets the requirements of our diverse community.

Our performance against each of the Outcomes has been presented together with examples of the work in NHS Borders that has contributed towards their achievement.

The main area where work is required relates to Outcome 2 – ie the services which we provide. We have relatively little data regarding equality outcomes for these services at present and recommendations are made as to how this can be tackled before the 2027 update.

2.3.1 Quality/ Patient Care

We need to develop systems to gather appropriate equality data for those accessing our clinical services. Limited data are available already – for example age and gender profile of people waiting for inpatient procedures, and attending for vaccination and screening but limited information is available about other protected characteristics.

2.3.2 Workforce

We do have good data about how our workforce is made up in terms of protected characteristics and have a range of policies and procedures to address our duties. A number of these are described in the report.

2.3.3 Financial

Resource will be needed to increase our data gathering and monitoring against protected characteristics as described in above.

2.3.4 Risk Assessment/Management

By completing and publishing this report, and producing a workplan to make further progress which will be reported in 2027 update, the Board's risks under the Act are managed.

2.3.5 Equality and Diversity, including health inequalities

NHS Borders has a Health Inequalities Strategy called THIS Borders, which has been approved by the Board. Whilst slow, progress has been made. Health Inequalities differ from the Equality Duty since it focuses on health outcomes.

The Board is meeting its duties under the 2010 Equality Act by receiving this paper.

2.3.6 Climate Change

2.3.7 Other impacts

2.3.8 Communication, involvement, engagement and consultation

This report has been produced with the assistance and engagement of colleagues across the organisation

2.3.9 Route to the Meeting

This report has not been to any committees before coming to the Board

2.4 Recommendation

The Board/Committee will be asked to confirm the level of assurance it has received from this report. We are aware that we need to do more to demonstrate and ensure equity in the clinical services provided by the Board. Using resources from the Scottish Inequalities Fund we have produced a Screening Equity Action Plan, and the effectiveness of this will be monitored over the coming period. We will use this learning to inform how we can ensure and monitor equitable access to our other clinical

services. In particular we propose annual reporting of primary care contacts, vaccination and screening attendance by protected characteristic.

- **Moderate Assurance**

3 List of appendices

NHS BORDERS

EQUALITY MAINSTREAMING REPORT

2025

EXECUTIVE SUMMARY

Welcome to our NHS Borders 2025 Equality and Diversity Mainstreaming Report. Every NHS Board in Scotland has a duty to comply with the Public Sector General Duty, the Equalities Act (2010), and Specific Duties Scotland Regulations (2012). This report includes routinely collected information and case studies to illustrate how NHS Borders is working towards mainstreaming as well as examining areas that require further improvement and development.

For NHS Borders, an anchor organisation which values equality and diversity, this report serves as a valuable tool for developing and embedding continuous improvement of mainstreaming equality.

The purpose of the Public Sector General Equality Duty is to ensure that all Public Bodies mainstream equality into their daily business by proactively advancing equality, encouraging good community relations and addressing discrimination. The Duty requires equality to be considered in relation to key health board functions including: the development of internal and external policies, decision making processes, procurement, workforce support, service delivery and improving outcomes for patients/service users.

Our eight reporting outcomes are:

1. We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected, and our workforce reflects our community.
2. Our services meet the needs of and are accessible to all members of our community.

3. Our staff treat all service users, clients and colleagues with dignity and respect.
4. We work in partnership with other agencies and stakeholders to ensure everyone has the opportunity to participate in public life and the democratic process.
5. We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the health inequality gap is reduced.
6. We work in partnership with other agencies and stakeholders to ensure the difference in rates of employment between the general population and those from underrepresented groups is improved.
7. We work in partnership with other agencies and stakeholders to ensure the difference in educational attainment between those who are from an equality group and those who are not is improved.
8. We work in partnership with other agencies and stakeholders to ensure we have appropriate housing which meets the requirements of our diverse community.

This report assesses our progress against these outcomes using relevant statistical data and giving examples of processes, policies and initiatives that help achieve them. The final section describes areas where further work is required. This will be reported on via the 2027 update report and the next full report which will be produced in 2029.

TABLE OF CONTENTS

1. INTRODUCTION

The primary roles of NHS Borders are prevent ill health, promote living well and treat those in need across the Scottish Borders. We respect and respond to the needs of our diverse communities and aim to achieve a positive and fair experience for all who access Health and Care services.

NHS Borders values and respects the diverse communities that make up the organisation. NHS Borders promotes equality for all and challenges prejudice and discrimination. Our Workforce is intended to be as diverse as the communities we serve given our responsibility to be an inclusive employer.

1.2 What is Mainstreaming?

Mainstreaming is defined as: the systematic integration of an equality perspective into our daily work. This involves policy makers from multiple departments and external partners.

Mainstreaming is a long-term method which ensures decisions made take into account the diverse requirements of all who access services delivered by NHS Borders i.e. patients, families, staff, our communities. This transparent report provides evidence and information about how NHS Borders is embedding Mainstreaming into our decision-making processes.

1.3 Timeline of Previous Reports

NHS Borders first Equality Mainstreaming Report 2013-17 set out its approach in working towards mainstreaming to reduce inequalities. Progress of the Equality Outcomes detailed in the first report was monitored in the updated report in 2015 through self-evaluation and production of an action plan:

- mainstreaming-report-2015.pdf

Following the 2015 report, a further update on NHS Borders progress was provided in the Equality Mainstreaming Report 2017-2021:

- mainstreaming-2017-2021-version-2-2.pdf

There was another full Mainstreaming Report published in 2021:

- Microsoft Word - 2021 NHSB Equality Mainstreaming Report 2021 Final for publication v2

NHS Borders produced a further update report in 2023:

- NHS Borders Mainstreaming Progress Report 2023 KK.pub

1.4 Reporting Outcomes

The following outcomes are used for reporting purposes following consultation:

1. We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected, and our workforce reflects our community.
2. Our services meet the needs of and are accessible to all members of our community.
3. Our staff treat all service users, clients and colleagues with dignity and respect.
4. We work in partnership with other agencies and stakeholders to ensure everyone has the opportunity to participate in public life and the democratic process.
5. We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the health inequality gap is reduced.
6. We work in partnership with other agencies and stakeholders to ensure the difference in rates of employment between the general population and those from underrepresented groups is improved.

7. We work in partnership with other agencies and stakeholders to ensure the difference in educational attainment between those who are from an equality group and those who are not is improved.
8. We work in partnership with other agencies and stakeholders to ensure we have appropriate housing which meets the requirements of our diverse community.

1.5 Demography of NHS Borders

To illustrate the demographics of the Scottish Borders the following tables are presented:

Table 1 - Demographic Overview of Scottish Borders Population	
Population of Scottish Borders (2022)	**116,900** (2022 Census)
Age Structures	15.3% under the age of 15.57 7% is 15 – 64 years old 27% is over the age of 65 (Scottish Public Health Observatory 2023)
Birth rate	**663 births** (birth rate of **7.1 per 1,000** compared to 8.4 per 1,000 for Scotland) (Scottish Public Health Observatory 2023)
Death rate	**1,504 deaths** (death rate of **992.9 per 100,000** compared to 1,117.2 for Scotland) (Scottish Public Health Observatory 2023)
Disability	**23.6%** have a long- term health condition which limits their day-to-day activities (2022 census Scotland)
LGBT	**67%**of young people said they knew someone who is **Lesbian, Gay, Bisexual or Transgender. 2.8%** (2.2% Scotland) identified **as LGB/ other** (Scottish Borders Council)
Child Poverty	**12.6%** of children live in **low- income** families however there are **10 areas** with **more than 15%** of children living in poverty (Scottish Borders Anti-Poverty Strategy 2021)
Fuel Poverty	Around **29%** are **fuel poor** (25% Scotland). This equates to roughly **16,000 households** (Scottish Borders Anti-Poverty Strategy 2021)
Religion in the Scottish Borders	**No Religion** 55.3% **Church of Scotland** 24.9%

	Roman Catholic 5.3% **Other Christian** 6.4% **Buddhist** 0.3% **Hindu** 0.1% **Jewish** 0.1% **Muslim** 0.3% **Sikh** 0.0% **Pagan** 0.42% **Other Religion** 0.2% **Not Stated** 6.7% **(2022 Scottish Census)**

Table 2 - Scottish Borders Population Main Language (2022 Scottish Census)	
	%
English	97.4
Gaelic	0.0
Scots	0.2
British Sign Language	0.0
Other	2.3

Table 3 - Declared Ethnic Groups in Scottish Borders (2022 census Scotland)	
	%
White - Scottish	74.6
White – Other British	19.2
White - Irish	0.7
White – Gypsy/Traveller	0.0
White - Polish	1.4
White - Other	2.1
Mixed or Multiple Ethnic Groups	0.7
Asian, Asian Scottish or Asian British	0.6
African	0.1
Caribbean or Black	0.0
Other ethnic groups	0.3

1.6 Profile Distribution of NHS Borders Workforce Compared to the General Population

1.6.1 NHS Borders Workforce & Scottish Workforce (all Scotland workforce)

The age demographic of the NHS Borders workforce is in line with that of the Scottish workforce. A similar distribution of the majority of workers aged between 30 and 59 years is seen in both NHS Borders and Scottish

workforces. Similarly to the Scottish workforce, the majority of NHS Borders workforce is white.

In 2020, the Scottish median hourly wage was £14.05 (excluding overtime for all employees) whilst the male and female median hourly wages of NHS Borders were £13.00 and £15.00, respectively. The median hourly wage for Scotland lies between the median hourly wage of NHS Borders' male and female employees.

1.6.2 NHS Borders Workforce & Scottish Borders Population

The 2022 Scottish Census data is available and shows the NHS Borders workforce is broadly representative of the population it serves. There are some notable exceptions such as the percentage of workers from a disclosed ethnic minority background being higher than that recorded in the surrounding population. Additionally, health & care has a majority female workforce at around 80% of all workers. Discussions are underway locally and nationally regarding increasing interest in health & care roles from individuals who identify other than female.

1.7 Legislative and Policy Background

All health boards across NHS Scotland have a moral, ethical and legal duty to treat everyone fairly and without discrimination. NHS Scotland is required to meet the aims of the Equalities Act (2010) and the Fairer Scotland Duty.

1.7.1 The Equality Act (2010) and Public Sector General Equality Duty

The Equality Act (2010) was implemented to protect those in the workplace and the wider society from discrimination. The Equality Act (2010) provides specific protection for people who fall under the nine "protected characteristics". These characteristics are:

- Age.
- Disability.

- Gender reassignment.
- Marriage and civil partnership.
- Pregnancy and maternity.
- Race.
- Religion or belief.
- Sex.
- Sexual orientation.

The three aims of the 2010 Act's Public Sector General Equality Duty are:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act.
2. Advance equality of opportunity between persons who share a relevant characteristic and persons who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

The Public Sector General Equality Duty replaces the previous Race Equality Duty (2002), the Disability Equality Duty (2006) and the Gender Equality Duty (2007).

1.7.2 Fairer Scotland Duty

The Fairer Scotland Duty, Part 1 of the Equality Act (2010) came into effect in April 2018. It holds public bodies in Scotland legally responsible for taking into consideration ways in which inequalities caused by socioeconomic disadvantage can be reduced.

To meet the obligations of the Duty, public bodies must achieve the key requirements:

1. To actively consider how they could reduce inequalities of outcome in any major strategic decision they make.
2. To publish a written assessment, showing how they've done this.

1.8 Importance of Inequality to Health

Equality is an important aspect of healthcare and is vital to ensure that the needs of everyone are met. In healthcare, equality is about treating people according to their requirements to provide a common standard of care that does not discriminate on the basis of their protected characteristics. In addition to equality, it is important to maintain a holistic approach to healthcare. A holistic approach considers all aspects of a person's identity and how these aspects integrate with and affect each other. The combination of equality and a holistic approach supports provision of an intersectional, person-centred approach.

1.9 NHS Borders Progress to Mainstreaming Equality

NHS Borders is committed to ensuring that equality is mainstreamed into working practices and policies to achieve a more inclusive workplace and to ensure NHS Borders is a provider of equitable public services.

NHS Borders commitment to equality and diversity is highlighted on our website which recognises these as essential components of healthcare and provides useful links for members of the public.

NHS Borders' Equality and Diversity micro site on the staff intranet enables staff to access useful information, policies and processes including interpretation and translation guidelines and advice on carrying out Equalities and Human Rights Impact Assessments. The micro site contains links to national and local equality materials, including a local demographic profile and the national Equality Evidence Finder.

Equality and Diversity e-learning is mandatory for all staff and remains an important aspect of corporate induction and continuous professional development. A domestic abuse awareness session is delivered to all staff at corporate induction which includes showing a DVD made by local women who have experienced domestic abuse. Domestic abuse and other forms of

Violence Against Women are covered in the Health Care Support Workers Training Programme. Equality and diversity issues are integrated into other corporate training packages such as Managing Sickness Absence, Child Protection and First Line Manager training.

NHS Borders works in partnership with other agencies to protect children and adults from harm. Staff are based in the co-located Public Protection Unit alongside staff from Police Scotland and Scottish Borders Council. Tackling Hate Crime is a priority. The unit co-ordinates child and adult protection. There is comprehensive guidance available online which includes information on trafficking, Female Genital Mutilation, Honor Based Violence, Child Prostitution and Children with Disabilities among others.

Equalities and Human Rights Impact Assessments examine the impact on the community when applying a proposed, new or revised policy or practice. These Assessments go beyond the public sector's legal duty of the Equalities Act (2010) by assessing the impact on:

- Health inequalities.
- Human rights.
- Socioeconomic circumstances.

2. PROGRESS AGAINST EQUALITY OUTCOMES

2.1 Outcome 1 - We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected, and our workforce reflects our community.

2.1.1 Workforce Demographic

Table 4 shows the distribution of workforce by gender for the years 2020 and 2024. The majority of our workforce is female. This proportion has remained approximately the same – around 80% from 2020 to 2024.

Table 4 – Workforce by Gender				
Gender	2020		2024	
	Number of staff	% of staff	Number of staff	% of staff
Female	2,621	81.78%	2790	79.9%
Male	584	18.22%	702	20.1%
Total	**3,205**	**100.00%**	**3,417**	**100.00%**

Table 5 shows the age distribution profile of the workforce for 2020 and 2024. It has remained stable, although there has been a decrease in the 19 and under age group (based on very small numbers) and a marked increase in the 65 and overs. The majority of our workforce is aged over 35 years, and this did not change from 2020 to 2040. There is a reliance upon, and historical trend of females going into the caring professions/healthcare roles. Conversations are taking place and action plans are being devised to increase interest in caring professions/roles from males and of course, those who might identify as non-binary.

Table 5 - Age Distribution				
	2020		2024	
Age Band	Number of Staff	% of Staff	Number of Staff	% of Staff
19 and under	23	0.72%	8	0.2%
20 - 34	634	19.78%	652	19.1%
35 - 49	1,099	34.29%	1,163	34.0%
50 - 64	1,389	43.34%	1,473	43.1%
65 and over	60	1.87%	121	3.5%
Total	**3205**	**100%**	**3,417**	**100%**

Figure 1 shows the ethnic origin profile for both years, with the majority of the workforce identifying as White. In 2020, some 75% of the workforce identified as white, with a 5 percentage point increase observed by 2024. The next largest ethnic group is Asian (2020 1.28%, 2024 3.2%) with an increase of some 2 percentage points since the last report. In the last full report, almost a quarter of the workforce preferred not to provide their ethnicity. This, while a legal right, does restrict the interpretation of these data which are crucial to recognising the need to take positive action to increase minority ethnic representation within the workforce. Encouragingly this percentage had dropped to 14% in the most recent figures, although more work may be needed to understand why this characteristic is still not well reported and/or recorded.

Figure 1

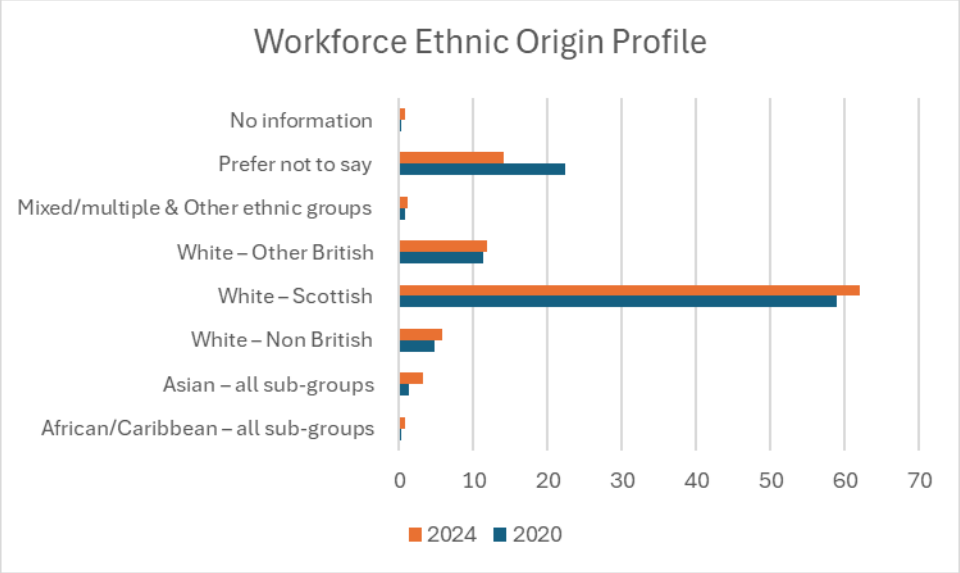


Table 6 shows that the proportion of the workforce with a medical condition has increased markedly between 2020 and 2024 – from less than 1% to almost 3% of the workforce. This may be due to delayed and ongoing effects of the Covid–19 pandemic.

It is reported that across Scotland 18% of the working age population have a disability, as defined by the Equality Act 2010 (St Andrews University). On that basis, there appears to be under-reporting within the workforce. Management and staff-side colleagues engaged the workforce in 2022 and invited employees to disclose whether they believe they have a disability, so that employee records may be updated.

Table 6 – Workforce Disability Profile		
Medical condition in past 12 months	**2020**	**2024**
Yes	0.81%	2.8%
No	97.94%	95.4%
Prefer not to say	1.06%	0.8%
No information	0.19%	1.0%
Total	**100%**	**100%**

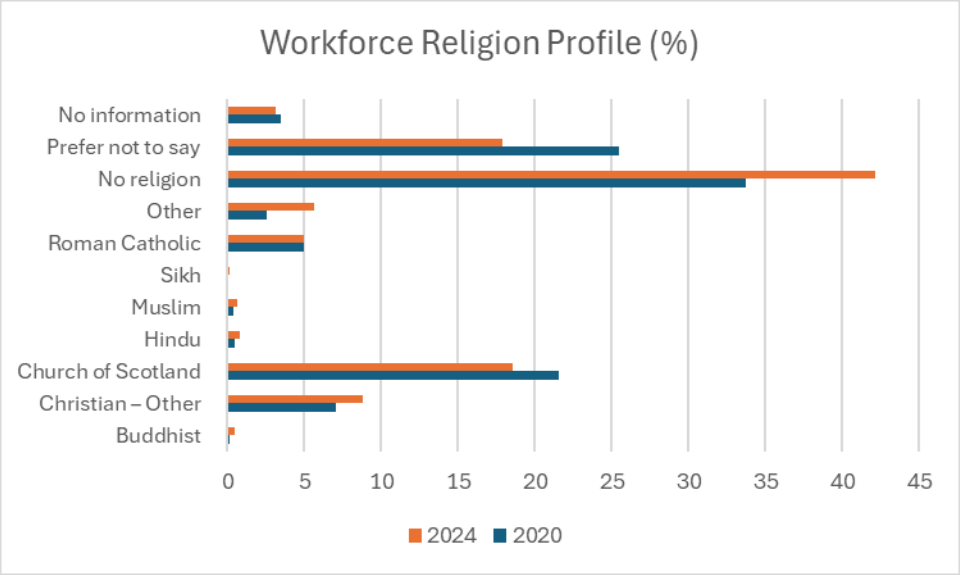
Table 7 shows the distribution of sexual orientation of the workforce. The majority of the NHSB workforce identifies as heterosexual – some 72% in 2020, rising to 78% in 2024. Small numbers in the other categories make detailed analysis difficult. During 2022, the Health Board's Equality, Diversity & Inclusion in Employment Group explored the 18% 'No information' figure, perhaps resulting in the fall in this category, which would account for the increase in reported heterosexuality. Table 8 shows the gender reassignment of the workforce, but the numbers are too low to make a meaningful analysis possible.

Table 7 - Sexual Orientation Profile		
Orientation	**2020**	**2024**
Bisexual	0.50%	1.1%
Gay/Lesbian	0.69%	1.0%
Heterosexual	71.89%	78.0%
Other	0.22%	0.5%
Prefer not to say	8.17%	7.0%
No information	18.53%	12.4%
Total	**100%**	**100%**

Table 8 – Workforce Gender Reassignment Profile		
Gender Assignment	**2020**	**2024**
No	96.88%	96.0%
Yes	0.12%	0.1%
Prefer not to say	1.28%	1.0%
No information	1.71%	2.8%

Regarding religion, Figure 2 shows that the largest proportion (42.2%) of our workforce has no religious affiliation and this has increased by 8 percentage points since 2020. Almost a fifth of the workforce preferred not to provide this information, down from almost a quarter in 2020.

Figure 2



2.1.2 NHS Borders Workforce Income

The following tables provide the distribution income by gender and staff group role.

Agenda for Change (AfC) staff have similar grades for any position. The grade is determined by the Job Description which is independent of gender. Hence the average difference is a result of staff quartile disposition and length of service in grade which attracts annual spine points.

Senior Management grades which are not part of AfC were combined with AfC because of small numbers (previously 8). This group has been split out as numbers have increased and have a more pronounced effect on AfC quartile 4. The gender pay gap of 16% is a reflection of the small numbers involved and can fluctuate significantly.

Medical and Dental staff have historically had a gender pay gap in excess of 20%. Over the last decade the thrust has been to attract more female staff. We are now seeing the results (8% gender pay gap) as it takes many years to get to consultant level. At 31 March 2024 the medical director is female and her associate and clinical directors consist of 5 females and 9 males. Downsized and re-organised, at the end of March 2025 the split is 5 females / 3 males.

Average Gender Pay Gap

Table 9	
Pay groups	**Gender Pay Gap**
AfC	- 6%
MEDICAL AND DENTAL	8%
Senior Manager Grades	16%
Organisation	14%

Comparison of hourly rate and staff numbers 2020/2024

Table 10 - AFC Staff 2020/2024 - Average of Basic Hourly Rate (£) by Gender					
Gender		**2020**	**Number of Staff**	**2024**	**Number of Staff**
Female		£15	2541	£19	2602
Male		£15	489	£18	587
Total			**3030**		**3189**
Table 11 - Medical & Dental Staff 2020/2024 - Average of Basic Hourly Rate (£) by Gender					

Gender	2020	Number of Staff	2024	Number of Staff
Female	£40	117	£47	114
Male	£43	94	£50	102
Total		**211**		**216**

Table 12 - Senior Manager Grades 2020/2024 - Average of Basic Hourly Rate (£) by Gender				
Gender	**2020**	**Number of Staff**	**2024**	**Number of Staff**
Female			£46	7
Male			£54	5
Total				**12**

Table 13 - All Staff 2019/2020 - Average of Basic Hourly Rate (£) by Gender					
Gender		**2020**	**Number of Staff**	**2024**	**Number of Staff**
Female		£16	2658	£20	2,723
Male		£19	583	£23	694
Total			**3,241**		**3,417**

Median Gender Pay Gap

Table 14	
Pay groups	**Gender Pay Gap**
AfC	5%
MEDICAL AND DENTAL	0%
Senior Manager Grades	2%
Organisation	**-25%**

Table 15 - Age					
Row Labels	**19 and under**	**20-34**	**35-49**	**50-64**	**65 plus**
Bands 1-4	0.5	21.7	28.1	44.1	5.5
Bands 5-7	0.0	17.7	38.0	42.4	1.9
Snr Manager Grades	0.0	0.0	33.3	66.7	0.0
Med&Dent 19-30	0.0	80.6	19.4	0.0	0.0
Med&Dent 31-45	0.0	8.1	48.6	43.2	0.0
Med&Dent 46+	0.0	0.0	46.6	48.6	4.7
Grand Total	**0.2**	**19.1**	**34.0**	**43.1**	**3.5**

Table 16 - Sexual orientation						
Row Labels	**Bisexual**	**Gay/ Lesbian**	**Heterosexual**	**Other**	**Prefer not to say**	**Don't Know**
Bands 1-4	1.1	1.2	76.9	0.5	6.2	14.2
Bands 5-9	1.1	0.9	78.7	0.6	7.4	11.3
Snr Manager Grades	0.0	0.0	66.7	0.0	25.0	8.3
Med&Dent 19-30	3.2	0.0	80.6	0.0	0.0	16.1
Med&Dent 31-45	2.7	0.0	83.8	0.0	0.0	13.5
Med&Dent 46+	0.0	0.7	81.1	0.0	11.5	6.8
Grand Total	**1.1**	**1.0**	**78.0**	**0.5**	**7.0**	**12.4**

Table 17 - Ethnicity								
Row Labels	**African & Caribbean**	**Asian**	**Mixed & Other Ethnic Groups**	**White - non-British**	**White - Other British**	**White Scottish**	**Prefer Not to Say**	**Don't Know**
Bands 1-4	0.3	1.6	6.3	7.8	67.5	14.5	1.0	1.0
Bands 5-9	1.4	3.0	4.7	13.4	61.7	14.3	0.8	0.7
Snr Managers	0.0	0.0	8.3	8.3	33.3	41.7	0.0	8.3
Med&Dent 19-30	0.0	35.5	12.9	25.8	22.6	0.0	0.0	3.2
Med&Dent 31-45	0.0	27.0	13.5	29.7	13.5	8.1	0.0	8.1
Med&Dent 46+	0.0	9.5	10.8	27.7	35.1	10.8	2.0	4.1
Grand Total	**0.8**	**3.2**	**5.9**	**11.9**	**62.0**	**14.1**	**0.9**	**1.1**

Table 18a - Religion						
Row Labels	**Buddhist**	**Christian - Other**	**Church of Scotland**	**Hindu**	**Jewish**	**Muslim**
Bands 1-4	0.4	6.9	15.6	0.3	0.0	0.1
Bands 5-9	0.1	9.6	22.2	0.7	0.1	0.2
Snr Managers	0.0	8.3	25.0	0.0	0.0	0.0
Med&Dent 19-30	25.8	9.7	3.2	3.2	0.0	6.5
Med&Dent 31-45	0.0	21.6	5.4	10.8	0.0	16.2
Med&Dent 46+	1.4	13.5	13.5	3.4	0.0	5.4
Grand Total	**0.5**	**8.8**	**18.6**	**0.8**	**0.0**	**0.6**

Table 18b - Religion						
Row Labels	No Religion	Other	Roman Catholic	Sikh	Prefer not to say	Don't Know
Bands 1-4	47.0	1.8	5.2	0.2	18.8	3.5
Bands 5-9	39.9	1.9	5.3	0.1	17.2	2.8
Snr Managers	25.0	0.0	0.0	0.0	41.7	0.0
Med&Dent 19-30	35.5	0.0	12.9	0.0	3.2	0.0
Med&Dent 31-45	27.0	0.0	8.1	0.0	2.7	8.1
Med&Dent 46+	27.0	2.0	11.5	0.0	20.9	1.4
Grand Total	**42.2**	**1.8**	**5.6**	**0.1**	**17.9**	**3.1**

Table 19 - Disability				
Row Labels	No	Yes	Prefer not to say	Don't Know
Bands 1-4	95.1	2.9	0.7	1.3
Bands 5-9	95.7	2.7	0.9	0.8
Snr Managers	100.0	0.0	0.0	0.0
Med&Dent 19-30	90.3	6.5	0.0	3.2
Med&Dent 31-45	100.0	0.0	0.0	0.0
Med&Dent 46+	94.6	2.0	2.0	1.4
Grand Total	**95.4**	**2.8**	**0.8**	**1.0**

Table 20 – Gender reassignment				
Row Labels	No	Yes	Prefer not to say	Don't Know
Bands 1-4	94.8	0.1	0.9	4.1
Bands 5-9	97.1	0.1	1.1	1.8
Snr Managers	100.0	0.0	0.0	0.0
Med&Dent 19-30	96.8	0.0	0.0	3.2
Med&Dent 31-45	100.0	0.0	0.0	0.0
Med&Dent 46+	95.3	0.0	2.0	2.7
Grand Total	**96.0**	**0.1**	**1.0**	**2.8**

Table 21 – Marital status						
Row Labels	Civil Partnership	Divorced	Married	Single	Widowed	Don't Know
Bands 1-4	1.4	6.3	50.2	40.5	1.3	0.4
Bands 5-9	0.4	5.7	59.0	33.4	0.7	0.8
Snr Managers	0.0	0.0	83.3	16.7	0.0	0.0
Med&Dent 19-30	0.0	0.0	16.1	83.9	0.0	0.0
Med&Dent 31-45	0.0	5.4	73.0	21.6	0.0	0.0

Med&Dent 46+	0.0	2.0	73.6	23.6	0.0	0.7

The following are examples to illustrate how NHS Borders is working towards Outcome 1.

2.1.3 NHS Borders Policies

NHS Borders uses progressive Once for Scotland policies which support equality, diversity and inclusion in the workplace. These policies include anti-discrimination; however, a number of these policies are currently subject to national review.

These policies include:

- Adoption & Fostering Leave.
- Annual Leave.
- Appraisal, PDP & Review.
- Embracing Equality, Diversity & Human Rights Equal Opportunities.
- Facilities Agreement.
- Fixed-term Contracts.
- Flexible Working Requests.
- Grievance.
- Induction.
- Managing Employee Capability.
- Managing Employee Conduct.
- Maternity and Paternity Leave
- Parental Leave.
- Recruitment and Selection.
- Redeployment.
- Retirement.
- Sickness Absence.
- Special Leave.
- Substance and Alcohol Misuse.

- Tackling Workplace Bullying and Harassment.
- Whistle Blowing.

2.1.4 Disability Confident Employer

NHS Borders is a Disability Confident Employer. This scheme guarantees interviews for applicants with a disability who meet the essential criteria for the job. We also have committed to supporting employment and providing reasonable adjustments where this is proportionate, affordable and can assist in keeping someone at work. NHS Borders is regularly audited by Department for Work & Pensions to make sure that it is fulfilling its Disability Confident accreditation/obligations for example, ensuring reasonable adjustments are in place to enable prospective disabled employees to attend an interview.

2.1.5 Equality, Diversity and Inclusion (EDI) in Employment Group

NHS Borders is committed to providing equal opportunities and fair treatment for all. The Equality, Diversity and Inclusion in Employment Group have several important roles for maintaining this commitment in the field of employment, including:

- Monitoring culture/behaviour and whether employees, students, volunteers and applicants believe the organisation treats people in a fair, consistent manner regardless of background.
- Building in a sense that NHS Borders is on a positive journey of constant improvement in the field of equality, diversity and inclusion.
- Having an action and outcome-focused outlook, investing in awareness/education, recognizing non-optimal performances and taking steps to change for the better.
- Encouraging harmony between different groups in the wider system.
- Collecting, collating and reporting on useful data to inform the equality agenda.
- Working to an annual work plan.

2.1.6 NHS Scotland Pride Pledge and Badge

For some years now, NHS Borders has been implementing the NHS Scotland Pride Pledge and Badge initiative to show support for LGBTQ+ people. NHS Scotland designed the badge as a symbol which identifies the wearer as someone that people in the LGBTQ+ community (including those from a minority ethnic background) can feel comfortable in approaching. The aim is to promote a message of inclusion as well as to acknowledge and raise awareness of the issues that members of the LGBTQ+ community can face when accessing healthcare.

2.1.7 Compassionate Leadership Programme

This programme fundamentally advocates for a style of leadership (and following) which is inclusive, considerate and caring. The programme, which is now into its 8th Cohort, incorporates a module on respecting what value-add diversity can bring to an organisation.

2.1.8 Diverse Workforce

The make-up of the NHS Borders workforce has shifted over the last 3-4 years, with a significant influx (almost 100) of international recruits from the Indian sub-continent, Middle and Far East and Africa.

Over the last two years NHS Borders has delivered training around Race & Equity and educated the workforce about Trans staff and service users.

2.1.9 Equality Staff Networks

Since the last report, three Equality Staff Networks, all Chaired by members of our Area Staff side, have been established. These are:

- **Minority Ethnic Staff Network.** This group is being established to provide a forum for staff from ethnic minority backgrounds to have a collective voice and to help ensure that NHS Borders policies and decisions take into account ethnic staff needs.
- **Disability Staff Network.** This network is for anyone who recognises themselves as having a disability or long-term health condition which has

an impact on their daily life lasting 12 months or more. It is a safe space for staff with a disability, seen or unseen, to meet and access moral support from each other. The network also gives staff with a disability the chance to have a voice and feed back to the Equality and Diversity Forum any issues and help ensure NHS Borders policies and decisions have taken into account disability needs.

- **LGBTQIA+ Staff Network.** The NHS Borders LGBTQIA+ Staff Network is led by, and is for, LGBTQIA+ NHSB staff to ensure that the organisation understands and incorporates our lived experiences to develop an inclusive and equal workplace. The group welcomes everyone who identifies as part of the LGBTQIA+ community, as well as allies interested in joining the network. It is a safe and inclusive space where challenges in the workplace can be discussed.

2.2 Outcome 2 - Our services meet the needs of and are accessible to all members of our community

We know that we need to strive to make improvements to the accessibility of our services. 32% of the data zones within the Scottish Borders are within the 20% most access deprived data zones in Scotland and this has specific challenges for health care access and provision.

NHS Borders is committed to providing an excellent healthcare service which is accessible to all patients and members of the public. Many people face difficulties either in accessing healthcare services, getting information or communication due to language, literacy or disability barriers.

Digital technologies are also an important part of the solution and should be available where possible to improve convenience, quality and choice. NHS Borders introduced 'Near me clinics' during the in 2020. This includes the use of video consultations, development of a national programme of work to increase the use of remote monitoring for long term conditions, online triage

tools for GPs and some third sector organisations providing services virtually. We continue to review the impact of these services on accessibility and outcomes.

We are aware that in future we need to have a systematic process to monitor equity of access to our clinical services and this is discussed in the "Areas for Development" section later in the report. For this year's report we have included data about equity in screening services as an example of what we will strive to present going forward.

The following are examples to illustrate how NHS Borders is working towards Outcome 2.

2.2.1 British Sign Language

The BSL (Scotland) Act 2015 requires public bodies in Scotland to publish plans every 6 years, demonstrating how they will promote and support British Sign Language (BSL). The BSL Action Plan was put together to support the BSL National Plan, published on 6th November 2023. The plan in NHS Borders (2024 – 2030) will have six key priorities. These priorities are consistent with the ten long-term goals of the National BSL Plan in Scotland. These are:

- **Public Services:** BSL users will be able to access public services without language barriers.
- **Early Years and Education:** Children who use BSL will get the same support for language and learning as their peers.
- **Post-School Education:** BSL users will have the same opportunities to succeed in college, university, and adult learning as everyone else.
- **Employment:** BSL users will have equal access to training, apprenticeships, and employment.
- **Health, Mental Health, and Social Care:** BSL users will have access to the same high-quality health and social care as everyone else.

- **Transport:** BSL users will have full access to accessible and safe transport information.
- **Culture and the Arts:** BSL users will have opportunities to participate in and enjoy culture and the arts.
- **Justice:** BSL users will have fair and equal access to the justice system.
- **Democracy and Public Life:** BSL users will have full access to political and civic participation.
- **Family Support and Social Connections:** BSL users will be supported to develop and maintain strong family and social connections

The BSL Plan aims to have a positive impact for members of the local BSL community accessing services. Where needs are met, this allows for open communication and better health outcomes. There are also likely to be improvements in quality of care by continuing to work in partnership with SBC who provide support for BSL users in the community through the Sensory Services Team. The BSL Plan supports the Public Sector Equality Duty, Fairer Scotland Duty and the Board's Equalities Outcomes by being proportionate and relevant and meeting the needs of the local BSL community. In part, it also aims to mitigate the health inequalities experienced by the local BSL community, primarily linked to accessing Public Services in BSL.

By ensuring greater access to fully trained and registered interpreters, having more Public Services information readily available in BSL, developing our own network of local BSL users (both deaf and hearing users) and by working in partnership with organisations across the Scottish Borders, we will meet the concerns raised by our local BSL community.

2.2.2 Interpretation and Translation Service

NHS Borders is committed to providing an excellent healthcare service which is accessible to all patients and members of the public. In order to achieve this, the Interpretation and Translation Service is used to help

overcome communication issues which can be a major barrier to accessing healthcare.

The Interpretation and Translation Service has been running within the Public Health directorate for approximately 15 years. A portion of the Equality & Diversity budget remains within Public Health and is used for paying for the Interpretation and Translation Service. This service provides interpreters and the translation of documents where there is a clinical need relating to a patient or to support staff.

A set of guidelines were drawn up to aid NHS Borders staff on the use of this service. The guiding principles of the Interpretation and Translation Service are detailed below:

- Where there are communication difficulties, patients and staff have a right to communication support.
- The responsibility to ensure effective communication lies with healthcare staff.
- Staff must establish if a patient or service user requires an interpreter, they must not decide themselves whether a person's English is adequate.
- Communication support should be provided using approved interpreters and translators.
- Interpreting and translation services should be provided to the patient free of charge.

Work is ongoing within the Public Health Directorate to develop an MS-Forms based system on the intranet which will further enable the efficient processing of interpretation and translation requests and facilitate ongoing audit. This will help to ensure that funds are being used in an equitable manner.

2.2.3 Screening Equity Action Plan

This action plan is partly funded from the Scottish Government Screening Inequalities Fund (SIF). This funding contributes to service improvement and development activities in target groups/priority communities. These are identified in the plan and by the Scottish Government using analysis of screening uptake and potential for access barriers across the screening pathway. We are able to determine access barriers from both published literature and local evidence. Each of the six outcomes measures detailed within this National Screening Equity Strategy 2023-2026 are described within Borders Screening Equity Action Plan.

Abdominal Aortic Aneurysm Screening

- **Widening accessibility** to clinics and screening by providing AAA screening community clinics in Borders locations in Duns, Kelso, Peebles, Hawick and Borders General Hospital (BGH).
- **Incorporating AAA screening in the new Learning Disability national annual health check** for those who have Learning Disabilities
- **Creating Hope in the Scottish Borders** action plan seeks to address mental health and physical health. This is supported via the Mental Health Improvement and Suicide Prevention multi-agency steering group. Patients who are receiving care from mental health services are **supported by their key worker** to attend their AAA screening appointment.
- Increasing knowledge, understanding and making every contact count (MECC) through training and awareness raising activities so that all public health delivery staff feel able to have confident conversations about the AAA screening programme.

Bowel Screening

- **Review uptake/non-attenders** by SIMD from last two screening rounds and work with GP Surgeries to establish barriers and support

development of initiatives to reduce these and increase participation.

- **Creating Hope in the Scottish Borders** action plan seeks to address mental health and physical health. This is supported via the Mental Health Improvement and Suicide Prevention multi-agency steering group. Patients who are receiving care from mental health services are **supported by their key worker** to attend their bowel screening appointment.

Breast Screening

- **Incorporating breast screening in the new Learning Disability national annual health check** for those who have Learning Disabilities– LDS annual health check nurse is now in post; a PH lead for LD is in place; support to continue implementation of the LD project objectives. TrakCare patient record system questionnaire to be developed to hold this breast screening information including date of screen and/or patients decision to participate.
- Increasing knowledge, understanding and making every contact count (MECC) through training and awareness raising activities so that all public health delivery staff (Joint Health Improvement Team, Wellbeing Service) feel able to have confident conversations about the breast screening programme. They will then **provide advice, guidance and support** to service users to make informed decisions about participating in this screening programme to increase uptake.
- Ensuring information is available and easily accessible in different languages.
- Locations around Scottish Borders for the mammogram supported by GP practice.
- Trans-woman of eligible age who are taking hormones will automatically be invited for breast screening if they have changed

their CHI number to reflect their female gender. Trans-men who have not had their breasts removed will automatically be invited to breast screening if they have not changed their CHI number to reflect their male gender.

- Mechanisms in place to catch anyone who hasn't been screened in the 3-year period (i.e. moved into an area, or turned 50 just after team have visited)
- Over 70 can request appointment (but unclear of risk vs benefits).

Cervical Screening

- Offering **staff smear clinics,** between April-June 2024, at the BGH to increase access.
- Provision of additional **ad hoc smear clinics** to promote cervical screening awareness and participation.
- Preventing screening opportunities being missed due to pregnancy, using the booking in process to establish who is pregnant and who is eligible for cervical screening during their pregnancy period.
- **Creating Hope in the Scottish Borders** action plan seeks to address mental health and physical health. This is supported via the Mental Health Improvement and Suicide Prevention multi-agency steering group. Patients who are receiving care from mental health services are **supported by their key worker** to attend their cervical screening appointment.
- Increasing knowledge, understanding and making every contact count (MECC) through training and awareness raising activities so that all public health delivery staff feel able to have confident conversations about the cervical screening programme.

Diabetic Eye Screening

- **Widening accessibility** to clinics and screening by providing DES screening community clinics in eight Borders locations. This helps to

address the rurality of Scottish Borders and the inadequate and expensive transport links, which are a barrier to patients participating in this screening programme.

- **Clinics held on Saturdays** in a central location provide additional capacity as well as increased opportunity to attend appointments outside of weekdays, when people may be working.
- **Screening slit lamp appointments are provided by community optometrists**, increasing access and opportunities for patients to attend as close to home as possible.
- **Patients phoned prior to appointments as a reminder** to the appointment mailed to them. They are asked if any additional support is needed to attend their appointment and this is put in place where possible.
- **Incorporating DES screening in the new Learning Disability national annual health check** for those who have Learning Disabilities.
- **Creating Hope in the Scottish Borders** action plan seeks to address mental health and physical health. This is supported via the Mental Health Improvement and Suicide Prevention multi-agency steering group. Patients who are receiving care from mental health services are **supported by their key worker** to attend their DES screening appointment.
- Increasing knowledge, understanding and making every contact count (MECC) through training and awareness raising activities so that all public health delivery staff feel able to have confident conversations about the DES screening programme.

Pregnancy & Newborn

Public Health Audit Facilitation 0.2 WTE/week provided to Pregnancy & Newborn Programme for Badgernet data cleansing/validation. To develop SOP for Badgernet user training. This will result in a KPI dashboard that will

provide accurate data for reporting helping identification of inequalities. Include equalities monitoring as part of the reporting process of SIF funded project.

2.2.4 People waiting for in-patient treatment by age and gender

Currently, we have data available to show the age and gender breakdown of people waiting for in-patient treatment. The table below shows this distribution. Regarding gender, there is a roughly equal ratio of females to males on the waiting list as is seen in the general population (52% of the population is female, 54% of the people waiting are female). There is a skew towards more older adults waiting for treatment but that may well reflect the natural trend as the chances of requiring healthcare increase with age. More analysis is required in this area.

Table 22 - age and gender breakdown of people waiting for in-patient treatment

Age Bands	Female	Male	Not specified	Grand Total
0-9	26	46		**72**
10-19	48	58	2	**108**
20-29	110	64		**174**
30-39	141	73		**214**
40-49	139	81		**220**
50-59	191	173		**364**
60-69	240	244		**484**
70-79	236	245		**481**
80-89	112	92		**204**
90-99	7	8		**15**
Grand Total	**1250**	**1084**	**2**	**2336**

2.3 Outcome 3 - Our staff treat all service users, clients and colleagues with dignity and respect.

NHS Scotland has the legal underpinning of Staff Governance. This is an obligation to be an exemplary employer and have sound people governance systems and processes. There is also a responsibility placed

upon staff to 'treat all staff and patients with dignity and respect while valuing diversity.' Any deviation away from these ideals is likely to lead to Management attention and attempts at remedial action. Any failure to remedy the situation could lead to investigation and use of HR Policies.

The Clinical Governance and Quality Directorate runs the Compassionate Leadership programme which is open to all members of staff within NHS Borders. This includes a session on Improving Equality, Diversity and Inclusion which involves discussions with staff around equality, diversity and Inclusion in the workplace and in day-to-day interactions.

Examples of work within NHS Borders which have contributed to this outcome are listed below.

2.3.1 Tackling Bullying and Harassment Policy

NHS Borders is committed to upholding a workplace free of bullying, harassment or intimidation of any nature. All employees have a responsibility and a right to treat and be treated by colleagues with dignity and respect irrespective of their gender, race or ethnicity, relationship or health status, pregnancy/maternity status, age, disability, sexual orientation, religion or belief system.

The policy is intended to support managers when dealing with bullying and harassment in the workplace by:

- Raising awareness in staff that a policy/procedure exists and how it works.
- Encouraging management and staff to raise genuine concerns using the policy/procedure.
- Achieving a position whereby management and staff are confident in the policy/procedure and feel comfortable when using it.
- Improving the reporting and handling of such incidents.
- Facilitating open discussion on the efficacy of the policy/procedure.

- Providing, where appropriate, access to confidential counselling, advice and support for victims of bullying/harassment at work.
- Providing a programme for the communication of the policy, monitoring its effectiveness and training for those involved in applying the policy.
- Raising awareness that all staff, patients and visitors have a responsibility to ensure that their actions, attitudes or behaviours are not distressing or upsetting to others. Additionally, managers and supervisors have a specific responsibility to be vigilant about identifying and dealing with bullying/harassment at work, ensuring implementation of and adherence to this policy.
- Providing access to responsive Occupational Health & Safety services.

2.3.2 Equal Opportunities Policy Statement

NHS Borders is committed to ensuring the elimination of all forms of discrimination on the basis of age, culture, disability, employment status, ethnic origin, faith, gender, gender reassignment, HIV status, marital status, nationality, offending record, political affiliation or trade union membership, race, religion, sexual orientation or social background.

It is important to recognise that equal opportunities means ensuring that there is a level playing field for all existing and potential employees by providing protection from unlawful discrimination. It does not mean treating everybody the same. The concept of equal opportunities may therefore involve positive action. Examples of positive action may include:

- Targeted staff training and development schemes.
- The use of specialist press for job advertising.
- Encouraging people of a particular race, gender or disability to apply for jobs wherever they are underrepresented in the current workforce.

- As part of implementing this policy, regular reviews of practices and procedures will be undertaken in partnership to ensure they are consistent with the principles and aims of equal opportunities in employment.
- There is consistent and objective application across the whole employment field with individuals being selected, trained and promoted entirely based on their abilities / potential and the requirements of the job.
- NHS Borders undertake Impact Assessments to ensure that equality and diversity measures have been considered and appropriate actions taken.

2.3.3 Equality, Diversity and Human Rights Policy

This policy sets out NHS Borders's commitment to the principles, as defined below, of equality, diversity and human rights in employment and sets out the approach to be followed to ensure that such principles are consistently met.

The aims of this policy are as follows:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010 and less favourable treatment of other categories of worker as set out within other relevant legislation.
- Advance equality of opportunity between people who share a protected characteristic (i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation) and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.
- Ensure that the organisation has due regard for the European

Convention of Human Rights (ECHR) in the discharge of its function.

The following principles and values are key to the achievement of these aims:

- Equality, iversity and human rights must be at the heart of NHS Borders and everything it does.
- Disadvantages suffered by people due to their protected characteristics will be removed or minimised in order to create an environment in which individual differences and the contributions of all staff are recognised and valued.
- Steps will be taken to meet the needs of people from protected groups where these are different from the needs of other people.
- Steps will be taken to reduce underrepresentation of people with particular protected characteristics and increase the diversity of our workforce, both at an organisational level and within different job roles.
- A zero-tolerance approach will be taken to intimidation, bullying or harassment, recognising that all staff are entitled to a working environment that promotes dignity and respect for all.
- NHS Borders will act as an agent for change within local communities by positioning equality, diversity and human rights at the heart of local delivery plans.
- While this will be achieved in part by being championed at a senior level, it can only be fully achieved through all those working within NHS Borders recognising and adhering to their own personal responsibilities in this regard, and NHS Borders will therefore take steps to ensure that everyone in the organisation understands their rights and responsibilities under the policy.
- NHS Borders will ensure that arrangements are in place to support

staff who have equality, diversity and human rights issues.

- Equality and diversity monitoring will be undertaken on a regular basis, with resulting improvement actions being identified and achieved.
- This policy will be subject to ongoing monitoring to ensure that it is being fairly and consistently applied and that the stated principles and values are being met. The policy will be subject to regular review, in partnership, to ensure that it remains fit for purpose.

2.3.4 Maternity and Paternity Policy

NHS Borders is committed to ensuring consistent and equitable treatment for its employees in the matter of maternity leave and pay. This policy and protocol take into account current employment legislation, associated codes of practice, Agenda for Change Regulations and progressive employment practice.

This policy and protocol are designed to answer the questions employees will have regarding maternity and paternity leave and pay and guides employees and managers through this complex and detailed subject. It includes detail of the criteria that have to be met to qualify for maternity and paternity leave and pay and the employee's obligation to NHS Borders, for example the relevant timescales to be met and forms that should be completed.

2.3.5 Parental Leave Policy

NHS Borders is committed to ensuring consistent and equitable treatment for its employees in the matter of parental leave. This policy takes into account current employment legislation, associated codes of practice, Agenda for Change Regulations and progressive employment practice.

This policy is designed to answer the questions employees will have regarding parental leave and pay and guides employees and managers

through this complex and detailed subject. It includes detail of the qualification criteria for parental leave and pay and the employee's obligation to NHS Borders regarding timescales and paperwork.

2.3.6 Flexible Working Policy

Flexible working opportunities benefit everyone: employers, employees and their families. NHS Borders knows that it makes good business sense to be open to flexible working requests from its employees; accommodating requests can help to retain skilled staff and reduce recruitment costs; to raise staff morale and decrease absenteeism; and can help the organisation to react to changing service provisions. For employees, changes to working patterns can greatly improve the ability to balance home and work responsibilities

2.3.7 NHS Borders Behavioural Framework

The framework defines the behaviours that NHS Borders staff must demonstrate for our organisation to perform effectively. Everything that NHS Borders does relies on individuals and teams working interdependently, with our patients at the heart of everything we do. This framework is a statement of who NHS Borders is, what our patients can expect from us and what we expect from each other.

2.3.8 Values Based Recruitment (VBR)

NHS Borders uses a Values based approach to recruitment. VBR is an approach to help attract and select employees whose personal values and behaviours align with those of NHS Borders. The values that are shared across Scotland's Health Service are:

- Care and compassion.
- Dignity and respect.
- Openness, honesty and responsibility.
- Quality and teamwork.

NHS Borders recognises that staff who are valued and treated well improve patient care and overall performance, and these values were developed as part of the 2020 Workforce Vision which aims to ensure that the health service has the workforce needed for the future.

NHS Borders adopted those values when the Corporate Objectives were developed. Whilst it is recognised the values are core values of the majority of our staff, NHS Borders aims to ensure that these are embedded explicitly and are a core element in how staff is recruited.

2.4 Outcome 4 - We work in partnership with other agencies and stakeholders to ensure everyone has the opportunity to participate in public life and the democratic process

NHS Borders works very closely with local partner organisations. There is close collaboration with Scottish Borders Council as part of the Health and Social Care Partnership, and the Tackling Health Inequalities in the Scottish Borders (THIS Borders) strategy is based on inter-sectoral collaboration.

2.4.1 Co-production Charter (2019)

In 2019, the Co-production Charter was implemented between Borders Care Voice and the Scottish Borders Health and Social Care Partnership and produced by the Scottish Borders Mental Health and Wellbeing Forum. This document ensures that the national standards of engagement with all mental health services in the Scottish Borders are applied. This means that those with experience of mental ill health, their carers, as well as people who use the services are all involved with any commissioning, change or redesign processes from beginning to end, including evaluation and review. The involvement of these groups ensures that their voices are heard and that their knowledge and experiences are valued.

2.4.2 Community Engagement

This is a purposeful process which develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue between everyone involved, aimed at improving understanding between them and taking joint action to achieve positive change. Effective community engagement and the active participation of people is essential to ensure that health and social care services are fit for purpose and lead to better outcomes for people. Across the Scottish Borders Health and Social Care Partnership our mission is 'to help the people of the Scottish Borders live their life to the full, by delivering services that place their needs at the heart of everything we do.' This mission cannot be achieved by working in isolation, and we are committed to improving the ways in which people, especially those with lived experience, their families, carers and groups experiencing inequality can have their voices heard in decision making that affects them. We want current and future users of the services we provide to know that their views on what is important to them are understood and that they have influence and choice over how their health and social care needs are met. To achieve outcome 4, we work to our organisational 'Involving People Framework'; a tool which service providers can use to help plan engagement activities and service users can refer to in order to find out what they can expect from involvement activities that take place for services we provide.

2.4.3 Money Worries App

Good financial health has a positive impact on overall health and wellbeing. The Money Worries App was developed to mitigate the effects of ongoing welfare reform as well as the wider impact of COVID-19. The App is intended to aid people by providing access to quality assured information, as well as giving support to prevent escalating money worries. The Money

Worries app is a digital directory with links to help with money, health, housing and work.

Co-developed by NHS Borders, Scottish Borders Council, Citizen's Advice Bureau, TD1 Youth Hub and Early Steps Parent's Group, the Money Worries App reflects the voices of much of the Scottish Borders' community.

The App is a timely resource considering welfare reform changes implemented over recent years which include:

- Universal Credit – Managed Migration of existing claimants.
- Pension Credit into Universal Credit.
- Abolition of Housing Benefits – housing costs within universal credit.
- Full rollout of Scottish Devolved Benefits.
- Scottish Child Payment.
- Potential to increase access to unclaimed benefits.

Against this economic backdrop, it is evident that the there is a need for continued support in the Scottish Borders to reduce poverty and inequality as well as improve health and wellbeing. Systems currently in place that convey the reality of poverty in the Scottish Borders include:

- Use of food banks.
- Experiences with benefits systems.
- Summer food programmes.
- Income before and after housing costs.

The Money Worries App could support an early intervention and prevention approach by ensuring people can access the correct information and support at the right time. This could reduce further ill effects on the mental health of people who are experiencing uncertain economic circumstances.

2.5 Outcome 5 - We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the health inequality gap is reduced.

We recognise that since the pandemic, health inequalities have been widening. The cost of living crisis has impacted on our patients, staff and wider community. NHS Borders is committed to being ambitious about tackling health inequalities and has undertaken a data review of the issues affecting our population. We will continue to review how we can make progress in accessing data that better supports rural populations to identify health inequalities.

To begin to share issues and learning in relation to health inequalities, the Public Health Team held a series of Health Inequalities workshops throughout 2023 and 2024. The workshops brought together staff and partners across the system to share concerns and direct us to areas of action. An inequalities workshop aimed at education colleagues is in preparation and will take place this year.

A Health Inequalities Programme Board has been developed to ensure appropriate representation and oversight of the work, through the Community Planning Partnership (CPP). The CPP has already recognized the importance of tackling health inequalities under Theme 3 of its work plan. We continue to work with partners across the Scottish Borders to advance this agenda.

2.5.1 Early Years Pathway Pilot Project

An Early Years Pathway Pilot project has run in partnership with the Scottish Borders Council Financial Inclusion Team as part of a pathway initiative. The project aims to improve access to benefits information, advice and support

for early years families. Midwives and health visitors can refer new and expectant mothers to advisors form the project for assistance.

2.5.2 Borders Older People's Partnership

The Borders Older People's Partnership (BOPP) is a professional planning & delivery group, acting on priorities raised by the Borders Older People's Forum and responding to local and national Prevention priorities collectively, reflecting our legal Equality Duty.

The BOPP Membership have recently engaged in Equalities & Human Rights Training and are now being consulted as key group for the views of Older People within their networks, to influence policy & strategy. This work is in its early days and is an incremental learning experience for all involved.

2.5.3 'Involving People' Framework

The 'Involving People Framework' is based around the seven national standards for community engagement: planning, inclusion, support, working together, methods, communication and impact. The inclusion, support and working together standards are of particular relevance in the delivery of outcome 5, and include engagement with stakeholders, including those on our Scottish Borders 'diversity database' to carry out extensive Equality and Human Rights Impact assessments.

2.5.4 Menopause Cafe

This is a local initiative under the umbrella of the national Menopause Cafe charity. This initiative aims to enable people gather to eat cake, drink tea and discuss menopause. In NHS Borders, there are both workplace and public-facing events. The cafes are offered in an accessible, respectful and confidential space, and are open for all, regardless of gender or age. There are also online events for those unable to take part in face-to-face cafes.

2.6 Outcome 6 - We work in partnership with other agencies and stakeholders to ensure the difference in

rates of employment between the general population and those from underrepresented groups is improved We recognise and fully support the need to work with partners to maximise access and skills to digital and mobile connectivity and to increase the diversity of jobs and learning and training opportunities within Scottish Borders. The Board also has a range of policies and processes to support this aim as a major employer in the area.

2.6.1 JobTrain Recruitment System

The JobTrain recruitment system, which is used for employee recruitment by NHS Scotland, has built-in anti-discrimination measures. Shortlisting managers are not provided with applicant data such as names, addresses and demographic information in order to eliminate unconscious bias. JobTrain provides a streamlined job application and candidate management process and will help to ensure a consistent approach to recruitment across the NHS in Scotland.

2.6.2 Recruitment and Selection Policy

NHS Borders aims to recruit and select the most suitable person available for each authorised vacancy that arises to help us to provide a high quality service.

Values Based Recruitment is an approach which attracts and selects students, trainees or employees on the basis that their individual values and behaviours align with the values of NHS Scotland. The purpose of Values Based Recruitment is to ensure that the future and current NHS Workforce is selected against these values so that we recruit the right workforce, not only with the right skills and in the right numbers but with the right values to support effective team working in delivering excellent patient care and experience. Values Based Recruitment can be delivered in a number of

ways: through pre-screening assessments, to values based interviewing techniques, role play, written responses to scenarios, and assessment center approaches amongst others.

NHS Borders aims to encourage a diverse workforce representative of the local communities and may consider taking positive action to encourage applications from under-represented groups. It aims to provide a working environment where staff are valued and respected, and where discrimination, bullying and harassment are not tolerated. It is the responsibility of everyone involved in the recruitment process within NHS Borders to ensure no job applicant receives less favourable treatment than any other job applicant.

2.6.3 Anti-Racism Plan

How well NHS Borders complies with this measure will be investigated within its first Anti-Racism Plan, using the 2022 Scotland Census as a general population benchmark or recent Household Survey.

2.7 Outcome 7 - We work in partnership with other agencies and stakeholders to ensure the difference in educational attainment between those who are from an equality group and those who are not is improved

As highlighted in previous Mainstreaming Reports, NHS Borders and Scottish Borders Council remain committed to reducing the poverty-related attainment gap. Through the CPP we are committed to identifying opportunities for NHS Borders to work with other agencies and stakeholders to ensure that we tackle fundamental inequalities, and the outcomes associated with that. NHS Borders continues to work alongside colleagues from Education Scotland, SEIC and the Scottish Government in order to support schools with the development of the Scottish Attainment Challenge.

Borders Children and Young People's Planning Partnership sets strategic direction for our Children's Plan and delivery of The Promise. NHS Borders has executive level representation to the partnership support the key workstreams.

As an anchor institution, we recognise the wider role that we play in our communities to support opportunities for learning and training to ensure that opportunities are available across our community. We are developing our role as an anchor institution to better understand the reach and impact we can have.

2.7.1 Integrated Children and Young People's Plan

As part of the Integrated Children and Young People's Plan, NHS Borders and the Scottish Borders Council are committed to reducing the poverty-related attainment gap. NHS Borders works alongside colleagues from Education Scotland, SEIC and the Scottish Government in order to support schools with the development of the Scottish Attainment Challenge. Progress and the key strengths in the first five years of the programme include:

- Schools working together to supplement Pupil Equity Fund plans across clusters.
- Working with Community Learning and Development (CLD) and third-sector partners to help schools deliver successful programmes for the most disadvantaged children and young people, and their families.
- Improvements in outcomes for care experienced children and young people, for example:
  - An increase in attendance and a reduction in exclusion rates.
  - Increasing attainment in literacy for school leavers.

- A higher proportion of Looked After young people in the Scottish Borders achieving qualifications in the Senior Phase than the national average.
- An improving trend in the percentage of school leavers entering a sustainable positive destination.
- Improvements in attainment for children and young people living within SIMD quintile 1 (Q1), for example:
  - A higher attainment in literacy than the national average at third and fourth level.
  - An increased attainment in numeracy at level early level.
  - An increase in overall attainment at SCQF levels 5 and 6 in the Senior Phase.

- Progress in closing the poverty-related attainment gap, for example:
  - In literacy, at the first level the attainment gap has been reduced and at first, third and fourth level, the gap is below the national average

2.8 Outcome 8 - We work in partnership with other agencies and stakeholders to ensure we have appropriate housing which meets the requirements of our diverse community

The cost of living crisis presents serious economic and social challenges for the Scottish Borders. Energy prices have more than doubled and in November of 2022 the Scottish Government estimated that around 35% of households in Scotland are fuel-poor and 24% are in extreme fuel poverty.

Over recent years, NHS Borders has worked in close partnership with Scottish Borders Council, local Registered Social Landlords and Police Scotland to ensure that families from Ukraine who have suffered significant trauma continue to be welcomed and supported have all the assistance they

require. NHS Borders established a working group to help aid access to health care services, GP and dental registration alongside this.

2.8.1 Affordable Warmth & Home Energy Efficiency Strategy (AWHEES)

Scottish Borders Council and NHS Borders are committed to creating an equal and fair environment, providing everyone with a chance to succeed. A key step in achieving this is tackling fuel poverty which is why the Affordable Warmth & Home Energy Efficiency Strategy (AWHEES) was created. The aim of the Strategy is to provide affordable warmth and healthy homes for everyone living in the Borders.

An overarching priority for the AWHEES is that the co-benefits of the Strategy are maximised and any unintended impacts of installing energy efficiency measures are minimised. It should be ensured that appropriate means to mitigate any unintended effects are put in place. All actions and interventions within this Strategy are based around the particular needs of homeowners and not just the house and tenure type, as well as being outcome focused, rather than just target compliance based.

The Priorities that work towards fulfilling the AWHEES:

- To work collectively with our partners to improve affordable warmth and energy efficiency in homes.
- To explore wider measures to better manage energy and increase warmth in the home.
- To ensure the AWHEES provides opportunities for all in the Scottish Borders.
- A diverse range of partners, stakeholders and housing experts participated in developing the AWHEEs. The programme of engagement activity included the following:
  - Consultation across the Strategic Housing Services and wider services at SBC.

- Engagement with the Borders Home Energy Forum focusing on the technical elements of the Actions, and the advice and support elements.
- An online public consultation.
- A series of semi-structured interviews, face-to-face or over the phone, with members of the Borders Home Energy Forum and their relative colleagues.
- Engagement with community representatives, NHS Borders and Health and Social Care.
- Engagement with the Energy Efficient Scotland Change Works in Peebles Working group and academics working on the monitoring and evaluation programme at the University of Edinburgh.

2.8.2 Strategic Group for Clinical and Care Oversight of Care Homes

The Strategic Group for CCOCH is a multi-disciplinary team made up of professional key leaders across Scottish Borders Council and NHS Borders. The group was originally formed in response to the Coronavirus pandemic. It aims to ensure appropriate clinical and care professionals across the Health and Social Care Partnership (HSCP) take direct responsibility for the clinical support required for each care home in the Scottish Borders, as set out in the requirements given by the Cabinet Secretary for Health and Sport Committee.

3. AREAS FOR DEVELOPMENT

Equality Mainstreaming is a long-term process. Although we have made good progress in setting up appropriate policies, procedures and structures, we are aware that much is still to be done. For example, NHS Borders does not routinely record information about all protected characteristics.

3.1 Tackling Health Inequalities

Although it aims to mitigate health inequalities rather than specifically focusing on protected characteristics, the "Tackling Health Inequalities in the Scottish Borders" (*THIS Borders*) strategy has been a major step forward and has provided a vital mechanism to plan and coordinate multi-agency work in tackling health inequalities. NHS Borders recognises that the most marginalised members our society have the poorest health outcomes, placing a significant demand on health services. Evidence shows that persistent health inequalities remain in both health outcomes and service experience in NHS Scotland. However, health inequalities are avoidable and can be mitigated on both an individual and structural level. Action taken by NHS Borders and its staff can directly and positively impact health inequalities. We will continue to engage enthusiastically with the THIS Borders work.

3.2 NHS Borders as an Employer

As a major employer in the Scottish Borders, the Board has worked hard to embed equality in its employment practices and policies. Examples of these initiatives were given under Outcomes 1, 3 and 6. We will continue to

support this agenda, and in particular, develop the Equality Staff Networks which have been established and were described under Outcome 1.

3.3 Equitable Service Provision by NHS Borders

We are aware that we need to do more to demonstrate and ensure equity in the clinical services provided by the Board. Using resources from the Scottish Inequalities Fund we have produced a Screening Equity Action Plan, and the effectiveness of this will be monitored over the coming period. We will use this learning to inform how we can ensure and monitor equitable access to our other clinical services.

As with many Boards, the number of people waiting for treatment has risen in recent years, largely as a result of the major disruptions caused by the Covid-19 pandemic. This makes it even more important that we seek to understand the demographics & requirements of those on our waiting lists. This currently amounts to over 11,000 people. There will also be some synergy between this work and the "Waiting Well" initiative. This initiative in the Scottish Borders is part of a broader NHS Scotland program designed to support individuals awaiting healthcare services. Recognising that waiting for medical appointments, treatments, or surgeries can be challenging, this initiative emphasizes proactive steps to maintain and improve health during these periods.

NHS Borders has implemented the "Waiting Wisely" campaign, which aligns with the national "Waiting Well" strategy. This campaign offers guidance on maintaining physical and mental well-being while waiting for medical services. Key recommendations include:

- **Following Clinical Advice:** Adhering to guidance from healthcare providers regarding exercises, lifestyle modifications, or other health measures.
- **Eating Well:** Maintaining a balanced diet to support overall health and bolster the immune system.
- **Staying Connected:** Engaging with friends, family, and community groups to foster social support and reduce feelings of isolation.
- **Staying Active:** Participating in regular physical activity, tailored to one's abilities, to enhance physical and mental health.
- **Managing Stress:** Implementing stress-reduction techniques, such as mindfulness or relaxation exercises, to cope with the uncertainties associated with waiting.

As well as people waiting for hospital care, we have large numbers of contacts in terms of primary care, vaccination and screening. We need to ensure we are meeting equality duties in these areas too. We will introduce a series of annual reports in each of these areas.

CONTACTS

@ public.health@borders.scot.nhs.uk

✉ Public Health, NHS Borders, Education Centre, Borders General Hospital, Melrose, TD6 9BS

☎ 01896 825560

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
Title:	**NHS Borders Performance Scorecard February 2025**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Authors:	**Hayley Jacks, P&P Officer** **Matthew Mallin, BI Developer**

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 2025 against the targets from the 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

The Performance Scorecard is presented to each Board meeting so that performance against the key standards can be scrutinised, and corrective action can be reviewed. During 2024/25 this report has been submitted to Scottish Government on a quarterly basis as a progress report against the Board's Annual Delivery Plan. We submitted our quarter 3 report to Scottish Government on 25 March 2025.

2.3 Assessment

Trajectories for Delivering Planned Care Targets

Index	New Outpatient (NOP)	Current Month	Current Performance	30/06/2024	30/09/2024	31/12/2024	31/03/2025
1	Over 104 Weeks	28/02/2025	203	0	0	0	0
2	Over 78 Weeks	28/02/2025	550	300	260	220	200
3	Over 52 Weeks	28/02/2025	1695	1411	1230	1019	850
4	Total List Size	28/02/2025	11517	10115	9450	8810	8310

Index	Inpatients/Day Case (TTG)	Current Month	Current Performance	30/06/2024	30/09/2024	31/12/2024	31/03/2025
1	Over 104 Weeks	28/02/2025	33	10	10	5	5
2	Over 78 Weeks	28/02/2025	163	250	229	210	200
3	Over 52 Weeks	28/02/2025	512	645	617	595	575
4	Total List Size	28/02/2025	2384	3165	3240	3330	3310

Trajectories for Delivering Unscheduled Care Targets

Index	Emergency Access	Current Month	Current Performance	30/08/2024	30/09/2024	31/10/2024
1	Emergency Access Standard	February 2025	60%	63.00%	64.50%	67.40%

Index	Delayed Discharges	Current Month	Current Performance	30/06/2024	30/09/2024	31/12/2024	31/03/2025
1	Delayed Discharges Actual	16/03/2025	68	69	50	46	32
2	Additions	16/03/2025	18	16	16	16	16
3	Removals	16/03/2025	19	21	16	16	16

As outlined above, we are not meeting some of the ADP trajectories. A narrative providing further detail can be found within the scorecard where available updates have been added. To clearly demonstrate where we are achieving or under achieving on standards, a summary of met targets for Planned Care and Delayed Discharge has been included within the scorecard.

Where services have been able to provide it, narrative is contained within the body of the scorecard, focusing on 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 EHRIA's as part of delivering 2024/25 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.

2.3.8 Route to the Meeting

The Performance Scorecard has been developed by the Business Intelligence Team with any associated narrative being provided by the relevant service area and collated by the Planning & Performance Team.

2.4 Recommendation

- **Awareness** – To note Board performance as at the end of February 2025.

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

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

PERFORMANCE SCORECARD

As at 28 February 2025

Month 11

Contents

Introduction

This report contains waiting times performance and hot topic measures and an appendix which demonstrates Annual Operational Plan (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). The report is shared on a quarterly basis with Scottish Government to report progress against the key performance measures contained within our annual Local Delivery Plan 2024/25.

Performance is measured against a set trajectory or standard. To enable current performance to be judged, colour coding is being used to show whether the trajectory is being achieved. A tolerance of 10% is applied to the standards to enable them to be given a RAG status. For standards where the trajectory is 0, the tolerance level is 1, anything higher the RAG status is red (for example waiting times and delayed discharges).

Current Performance on Annual Delivery Plan (ADP) Targets

Trajectories for Delivering Planned Care Targets

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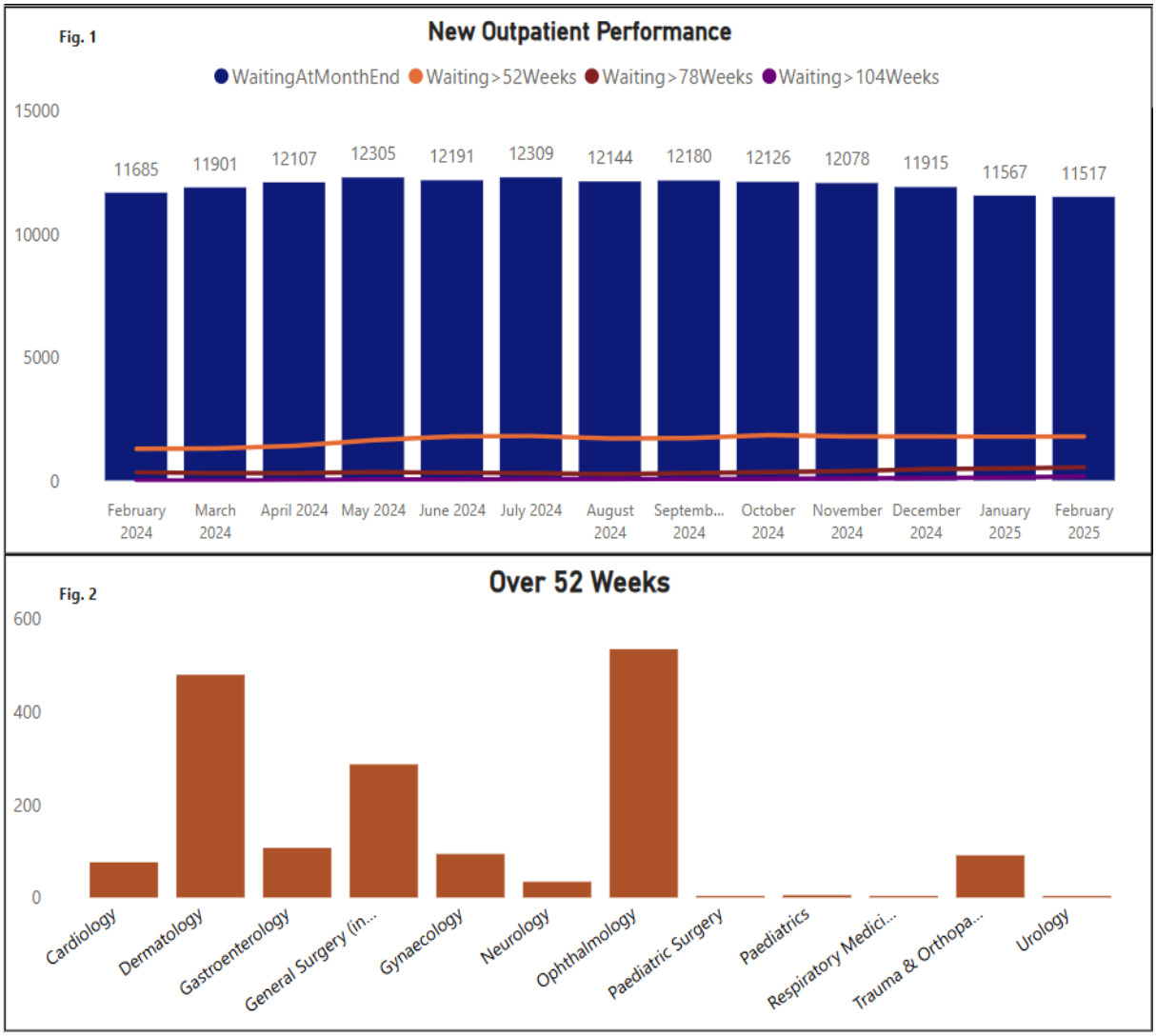
Outpatients waiting times



Although progress was made reducing the number of patients waiting > 52 weeks from June 2023 to February 2025 (1,951 to 1,214 patients; 37% reduction), the number of long waits have increased again over the last year (up to 1,685 patients, a 39% increase).

Four high volume specialties account for 80% of these waits: Ophthalmology, Dermatology, General Surgery and Gynaecology. The other challenged specialties include Gastroenterology, Orthopaedics, Cardiology and Neurology. 5 out of the 8 specialties have had workforce/recruitment/capacity issues.

The high volume of "urgent" referrals to most of these specialties has also impacted on their ability to see long waiting patients.

To improve performance, the service is focussing on:

- Targeting Validation of long waits.
- Targeting Capacity in specific procedures

- Targeting Capacity where we are an identified shortfall currently through capacity planning.

The service is beginning to plan a detailed specialty-specific plan of recovery actions to remove the backlog.

While we have stabilised our overall Outpatient waiting time position during 2024/25, there are key capacity issues that are providing a significant challenge to bringing all waits within 52 weeks sustainably.

Out most significant challenges are:

- Dermatology remains our most significant challenge due to chronic recruitment issues within this specialty. While we have addressed lesion referrals as a priority, we have struggled to address routine rash waits. With support from NECU and Forth Valley HB we believe we have plans now in place for 2025 for joint appointments that will support further improvements.

- NHS Borders has also struggled to appoint to consultant Ophthalmology posts, and partner Boards have not been able to provide support. This has directly impacted cataract surgery capacity, and the rate we have been able to recover waiting times. We believe we are now looking to appoint to vacancy session following interview and are hopeful this will support accelerated recovery of Outpatient and Cataract surgery waits in the Borders.

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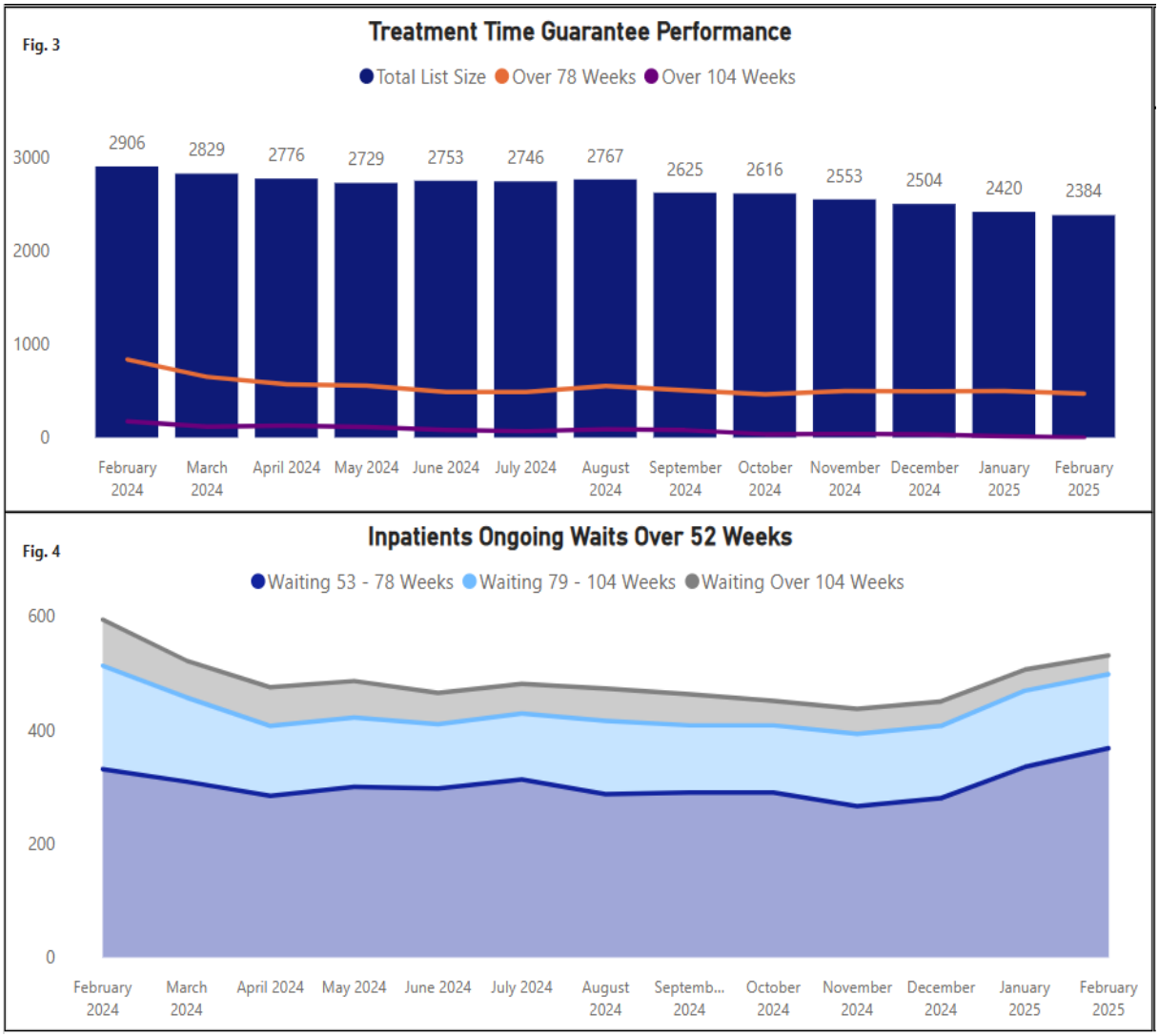
TTG Performance Against Trajectory- All Specialties



The total backlog of patients waiting for surgery has remained stable over the previous two-year period. Focus on patients who have waited longest for surgery over this period has changed the shape of the list, with the number of patients waiting over 52 weeks reducing from a peak of 811 (30th April 2023) to 508 patients (31st Jan 2025). There is still a significant backlog of patients requiring operations without a full plan for recovery.

To improve performance, the following areas are of focus:

- Theatre productivity will be improved to achieve a minimum of 85% utilisation.
- Cataract list productivity
- Elective Day Case rates
- 23-hour surgery Rate
- Arthroplasty LOS

The service is beginning to plan a detailed specialty-specific plan of recovery actions to remove the backlog.

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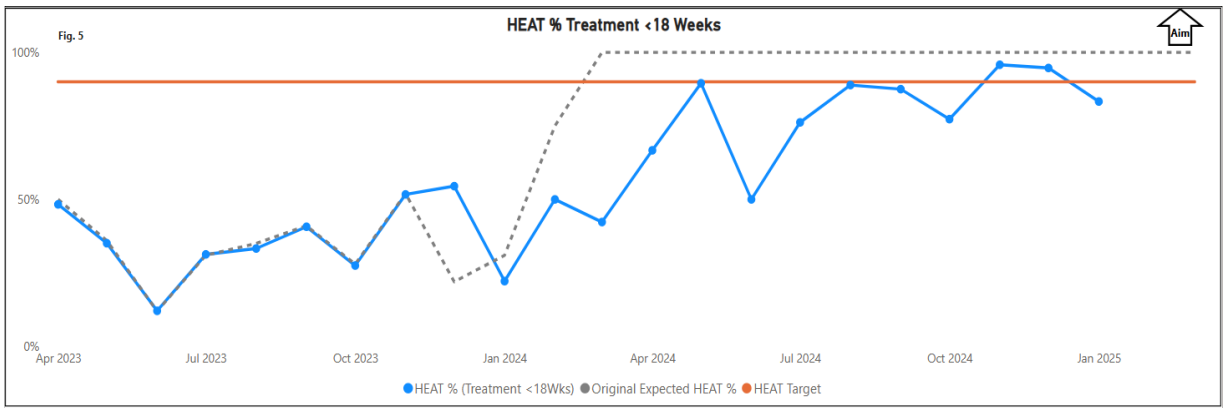
Mental Health Waiting Times – CAMHS



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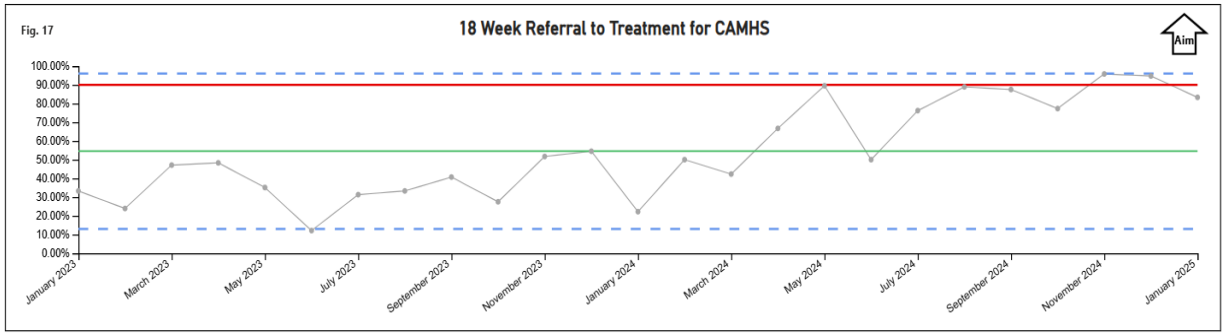

Plan to reduce CAMHS waiting times

- The implementation of referrals from all schools to CAMHS for neurodevelopmental queries was finalised in Spring 2024. Schools are currently our primary source of referrals for neurodevelopmental queries, resulting in a higher standard of referrals.
- We are currently engaged in a project to review inpatient services throughout Scotland, recognising the ongoing challenge of accessing specialist beds for young people. This has put pressure on our adult acute inpatient service. Our Advanced Clinical Nurse Specialist in CAMHS has enhanced the Multidisciplinary Team approach to ensure that assessments and treatments are carried out by the most suitable professionals.
- We continue to meet with stakeholders via a quarterly meeting and we have excellent engagement from several stakeholders such as BANG, Children 1st, Educational Psychology, School Nursing etc.
- Work was carried out which involved creating comprehensive support materials for redirecting referrals, including providing information in redirection letters with links to websites and QR codes. These support materials are also utilised by our Duty Nurse. A Duty Nurse rota has been implemented to accommodate the rise in enquiries stemming from our expanding Internal Waiting List.
- We funded 100 parents of primary age children who had received an ADHD diagnosis/assessment with us to access EPIC Think Learn Online Platform, which is a self-delivery with support model.

    - It contains a range of resources focused on key neurodiversity related issues including booklets, audios, videos, webinars on relevant topic such as masking, anxiety, food/eating and sensory processing. Increasing parental knowledge about

neurodiversity and practical strategies will benefit not only these 100 children, but also their siblings and potentially their wider family and friendship groups.

- In addition, the teacher of each of these 100 children received access to 8 research-based classrooms applicable CPD webinars and whole class teaching resources.

One of the main priorities regarding CAMHS is to consistently conduct new patient assessment appointments with a specific emphasis on meeting the 18-week Referral to Treatment (RTT) Annual Delivery Plan (ADP) Target. In November, 95.8% of CAMHS patients were seen within the 18-week HEAT target, and in December, this figure was 94.7%. CAMHS maintains a weekly monitoring of waiting times to ensure that patients are seen within the 18-week timeframe.

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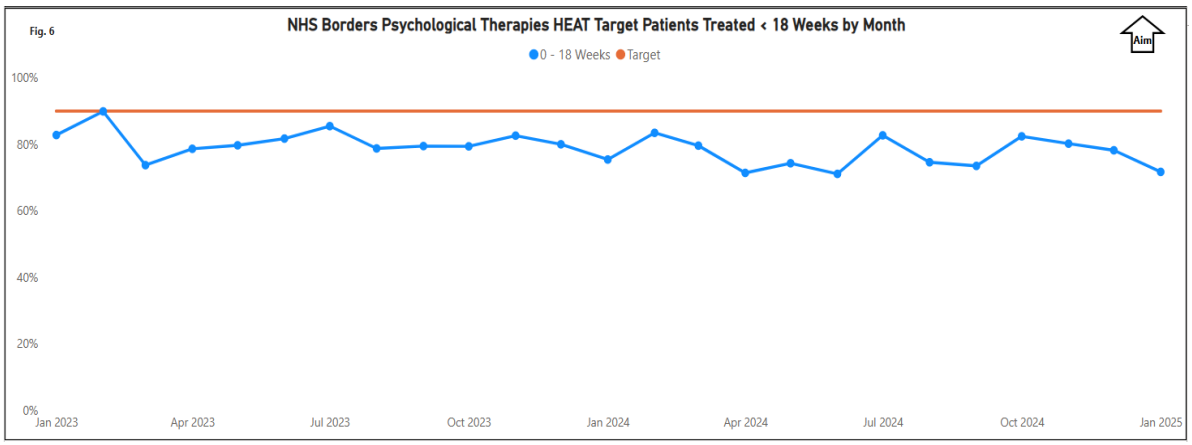
Waiting Times- Psychological Therapies



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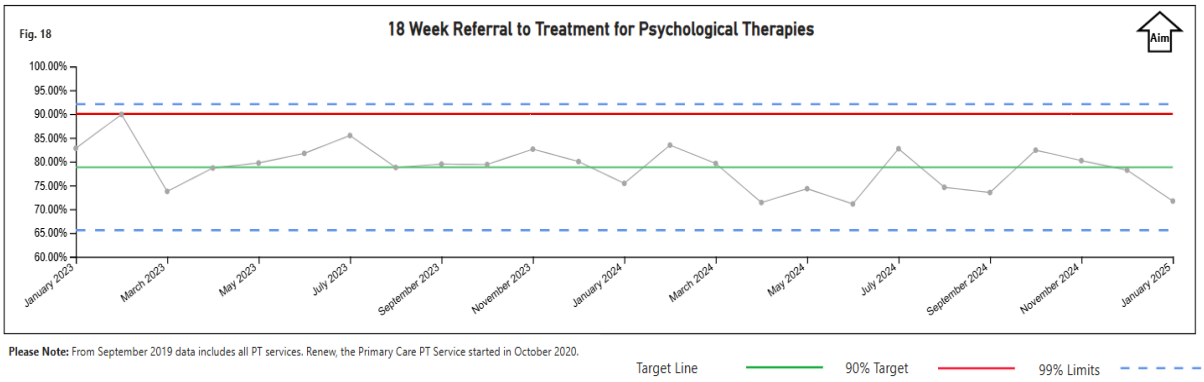

What is the data telling us?

We are not meeting the LDP target of 90% of those who start psychological therapy to do so within 18 weeks. In January 2025, 71.68% of those who started psychological therapy did so within 18 weeks. Of those waiting 90.15% have waited under 18 weeks, we have no one waiting over 52 weeks and are working hard to reduce all our longest waits.

Why is this the case?

In January 2025, we started treatment with 173 people, a significant increase from last month (87). This included a higher proportion of those who started treatment who had waited over 18 weeks (49) from last month (19) which contributed to an overall lower completed wait performance of 71.68%. This is positive because it means we are seeing some of our longer waits but does bring our overall performance down. The data is also telling us that we had a significant increase in referrals in January 2025 of 314 compared to 250 the previous month and was the highest number or referrals we have received since March 2024. The areas we saw increased demand during this period were adult mental health – primary and secondary care, substance use psychology and paediatric psychology.

What is being done to improve performance?

We monitor our services to make sure that they are as productive as possible and performing according to nationally agreed job plans. We are in the middle of our service review which is considering ways to improve our performance; although this is challenging due to gaps in services, the way the services are structured and the need to make savings. We have recently completed a piece of work where we have made some estimations regarding our trajectory for

the remainder of this financial year. We estimate that our performance in the last quarter will range between 77% and 80% with a projected 564 people being on our waiting list by the end of the year. We have engaged 1.4wte locums in AMH psychology who have had a positive impact on the waiting list, but this will be limited as they will only be working for 3 months. We are currently working on a proposal to engage some fixed term psychology input to assist with reducing our longest waits.

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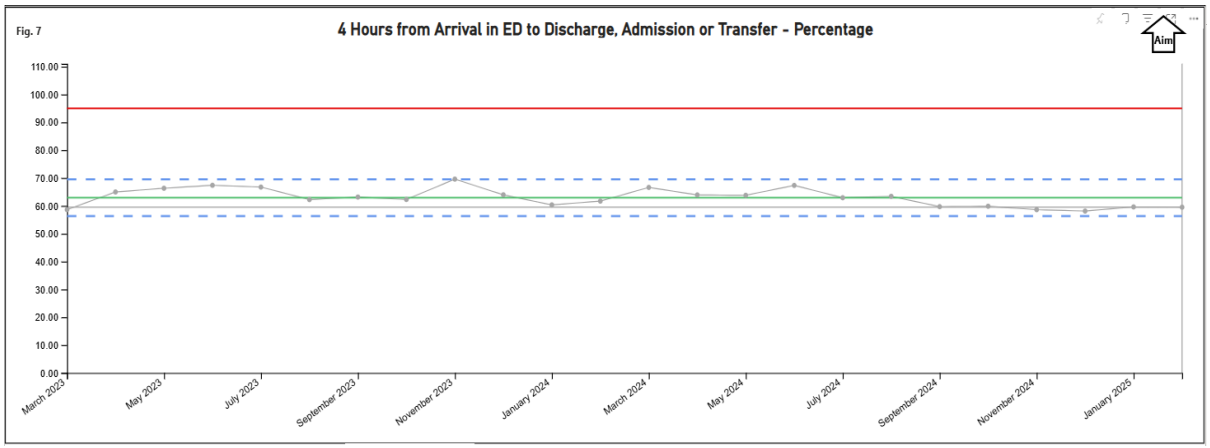
Unscheduled Care Performance - 4 Hour Emergency Access Standard Performance



Unscheduled care services at NHS Borders continue to experience significant pressure, which has created significant challenges achieving the 4-hour emergency access standard. In February 2025 there were **2339** unplanned attendances to the Emergency Department (ED), with **946** breaches. Performance against the standard was **59.56%** vs 60.9% in January 2025.

The signs of the current challenges are clear with sustained pressures in the community, long waits in the ED, increased turnaround times for ambulances and the significant real time risks for those who are unable to access timely assessment due to capacity and workforce issues.

Following NHS Board approval for the ED Workforce Review, a programme of recruitment remains underway to implement the recommendations across Nursing and Medical workforce. Additional Senior Nurses have been appointed to following a competitive recruitment process. Recruitment for additional overnight medical workforce is now underway.

Our Acute Flow Improvement Programme in its current form has been paused and it is likely to be superseded by a more targeted set of actions that will be derived from the soon to established Unscheduled Care Programme Board.

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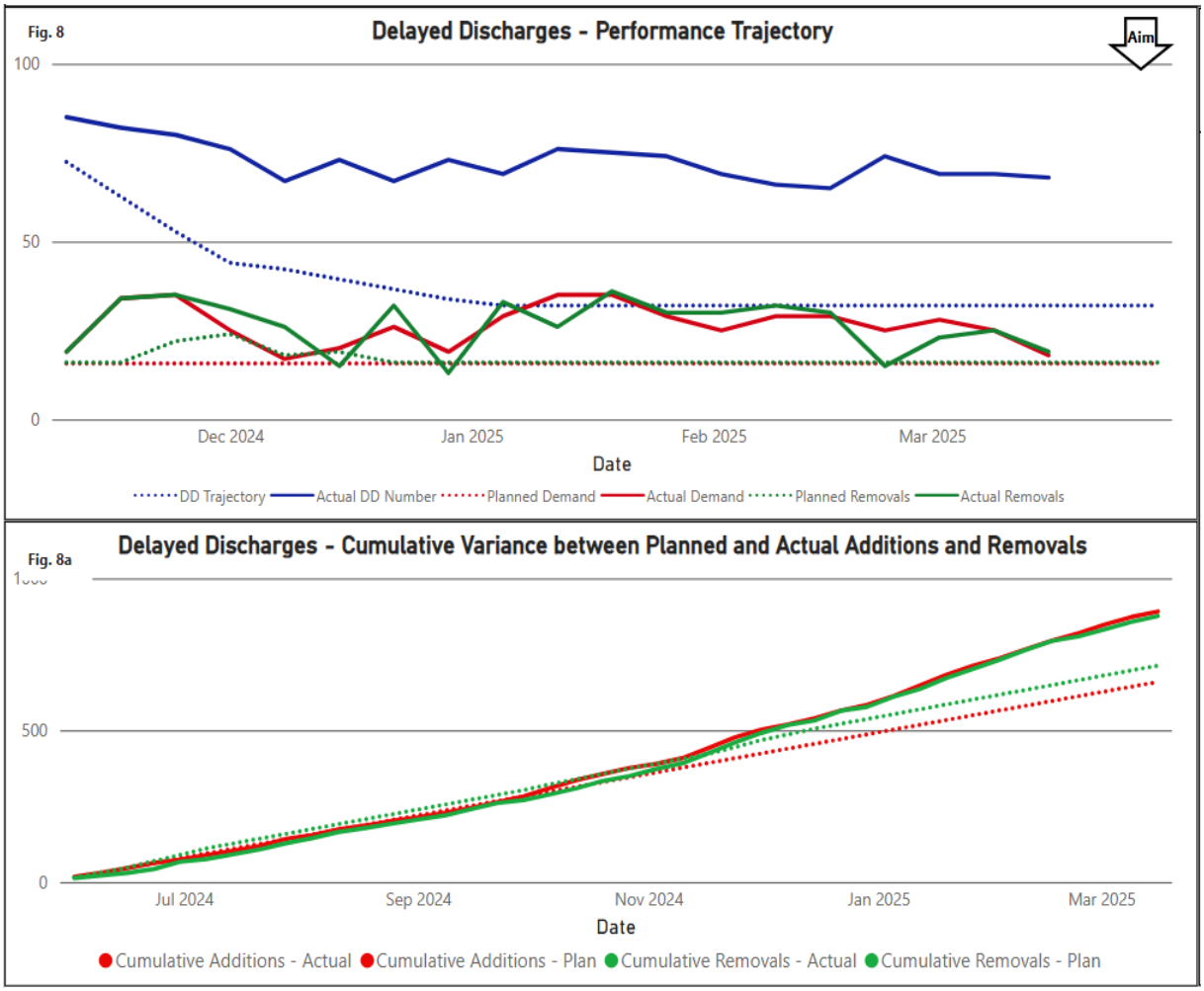
Delayed Discharge



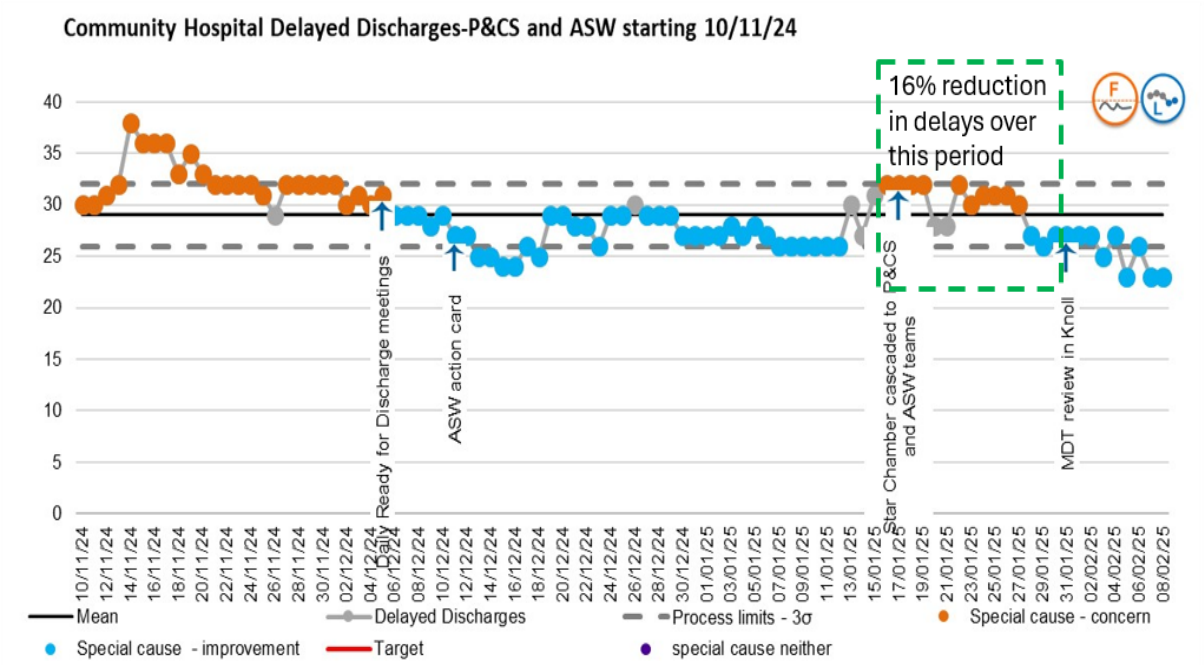
Performance:

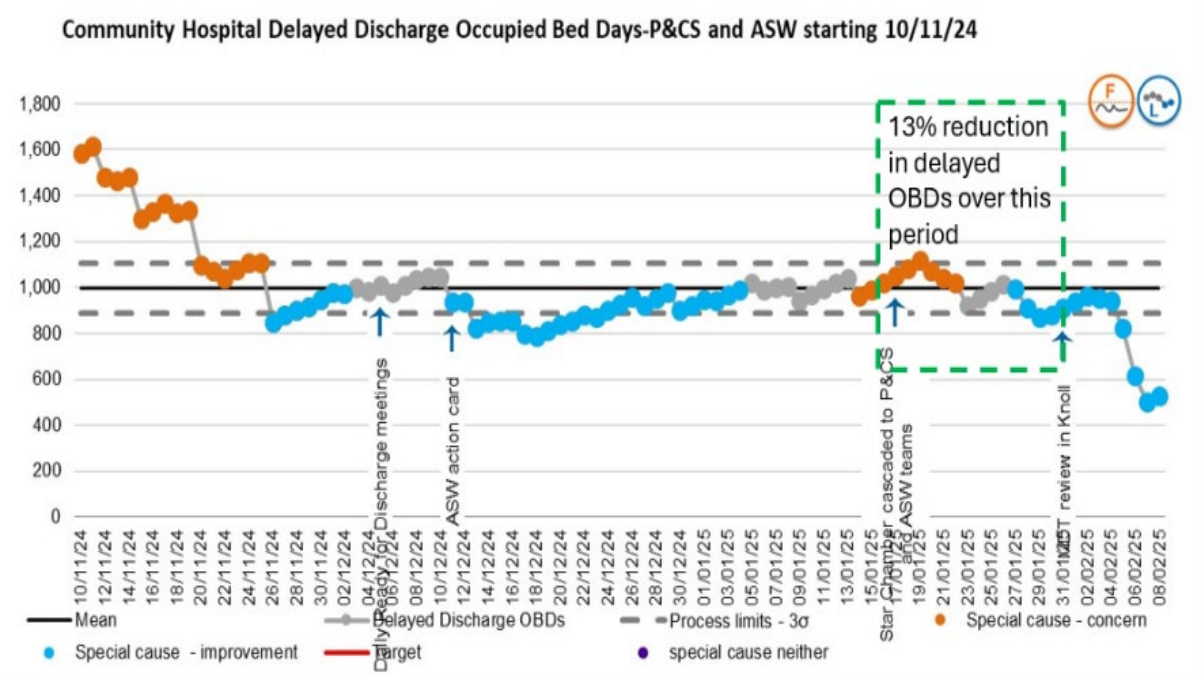
Our performance is worse than the forecast trajectory. At the time of writing (11 March 2025), we have 69 people waiting for care as 'delayed discharges' against a trajectory of 31, which is significantly above our trajectory.

As of 11 March, our delayed discharge breakdown was summarised as below:

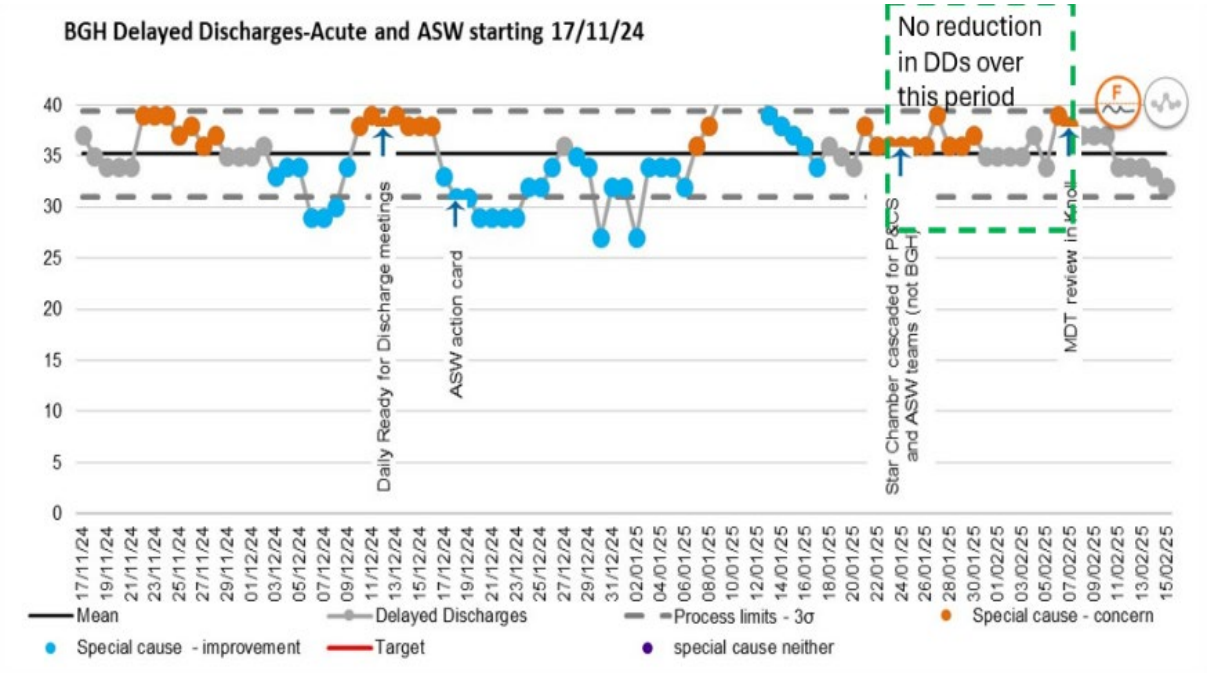
	Number of people delayed	% of people delayed	Occupied Bed Days	% Occupied Bed Days
Assessment	14	20%	193	5%
Homecare	14	20%	488	13%
Adults with Incapacity	12	17%	646	17%
Residential care	17	25%	516	14%
Nursing care	6	9%	561	15%
Housing/other	6	9%	1378	36%
Total	**69**	**100%**	**3,509**	**100%**

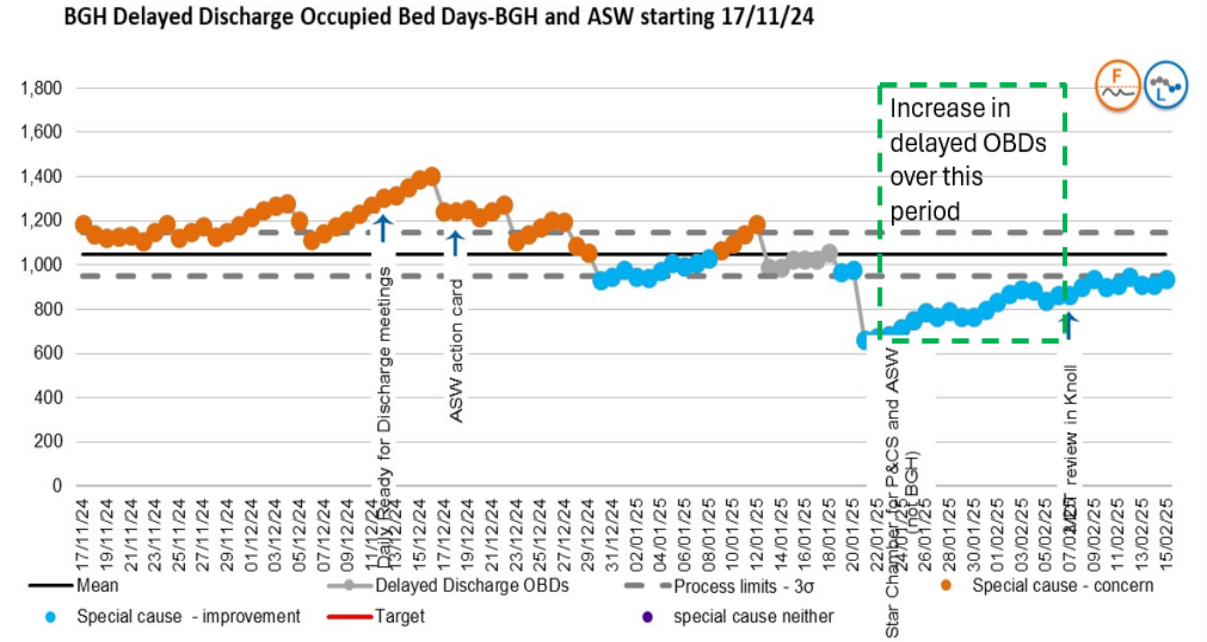
As noted in the previous Board update, our focus on process improvements is now well underway. To support this, a Star Chamber approach was established for the Community Hospitals in partnership with Adult Social Work colleagues to ensure that all relevant processes are being followed to expedite discharge (e.g. discharge planning from admission, timely referral to social work, choices policy, and moving on policy). Initial progress made by the Community Hospital and Adult Social Work team is outlined in the two charts which relate to the Community Hospital position below. In addition, significant work has been undertaken to transfer patients from the Knoll in the context of the RAAC situation within parts of the ward. This also had an impact on further reducing delays, and the Community Hospitals have sustained this level of delay following the closure of the Knoll.





For comparison, the BGH did not undertake the Star Chamber approach, and for the purposes of this report we can effectively use the BGH as a control. We can see that the same impacts were not experienced. It is worth noting that significant levels of care capacity remain available so this is not as a result of a lack of capacity.





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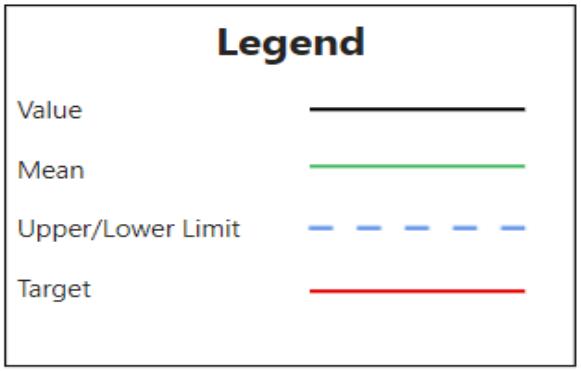
Appendix to Main Performance Scorecard – Performance Against Previous Agreed Standards

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

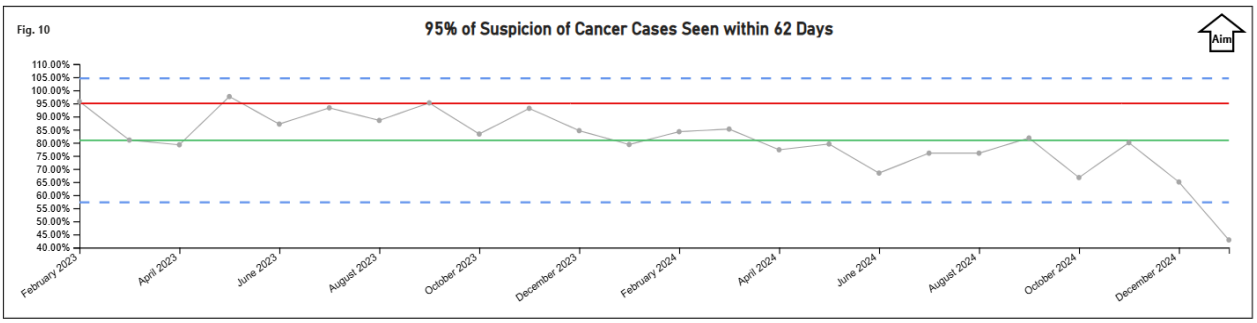
Symbols

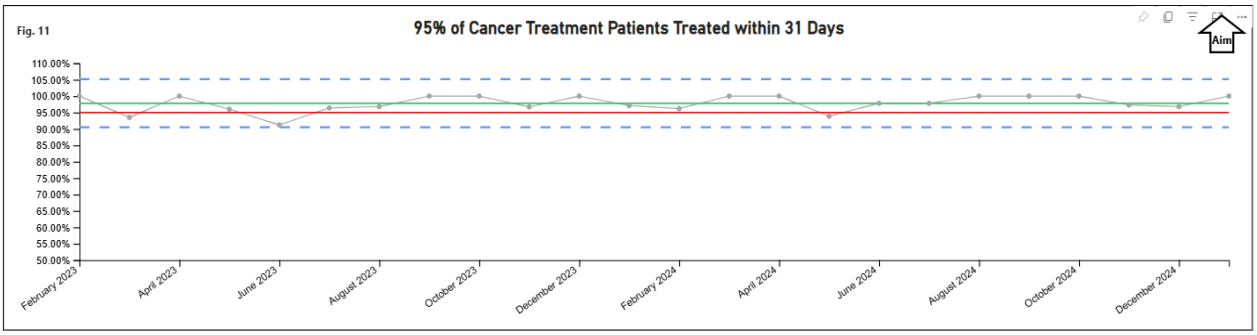
Better performance than previous month	↑
No change in performance from previous month	↔
Worse performance than previous month	↓
Data not available or no comparable data	-

Key Metrics Report Annual Operational Standards

Index	Measure	Target/Standard	Last Period	Last Position	Current Period	Current Position	Performance
1	Cancer Waiting Times - 62 Day Target	95% patients treated following urget referral with suspicion of cancer within 62 days	31 December 2024	65.00	31 January 2025	42.90	
2	Cancer waiting Times - 31 Day target	95% of patients treated within 31 days of diagnosis	31 December 2024	96.80	31 January 2025	100.00	
3	New Outpatients - Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	31 January 2025	7,915.00	28 February 2025	7,890.00	
4	New Inpatients - Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	31 January 2025	1,647.00	28 February 2025	1,606.00	
5	Treatment Time Guarantee - Number not treated within 84 days from decision to treat	Zero patients having waiting longer than 84 days.	31 January 2025	222.00	28 February 2025	158.00	
7	Diagnostics (8 key tests) - Number waiting >6 weeks	Zero patients waiting longer than 6 weeks for 8 key diagnostic tests	31 January 2025	688.00	28 February 2025	755.00	
8	CAMHS - % treated within 18 weeks of referral	90% patients seen and treated within 18 weeks of referral	31 December 2024	94.70	31 January 2025	83.30	
9	A&E 4 Hour Standard - % patients discharged or transferred within 4 hours	95% of patients seen, discharged or transferred within 4 hours	31 January 2025	60.00	28 February 2025	60.00	
10	Delayed Discharges - Patients delayed over 72 hours	Zero patients delayed in hospital for more than 72 hours	31 January 2025	59.00	28 February 2025	56.00	
11	Psychological Therapies - % treated within 18 weeks of referral	90% patient treated within 18 weeks of referral	31 December 2024	78.20	31 January 2025	71.70	
12	Drug & Alcohol - % treated within 3 weeks of referral	90% patient treated within 3 weeks of referral	30 September 2024	99.00	31 December 2024	96.00	
13	Sickness Absence Rates (%)	Maintain overall sickness absence rates below 4%	31 January 2025	6.97	28 February 2025	4.86	

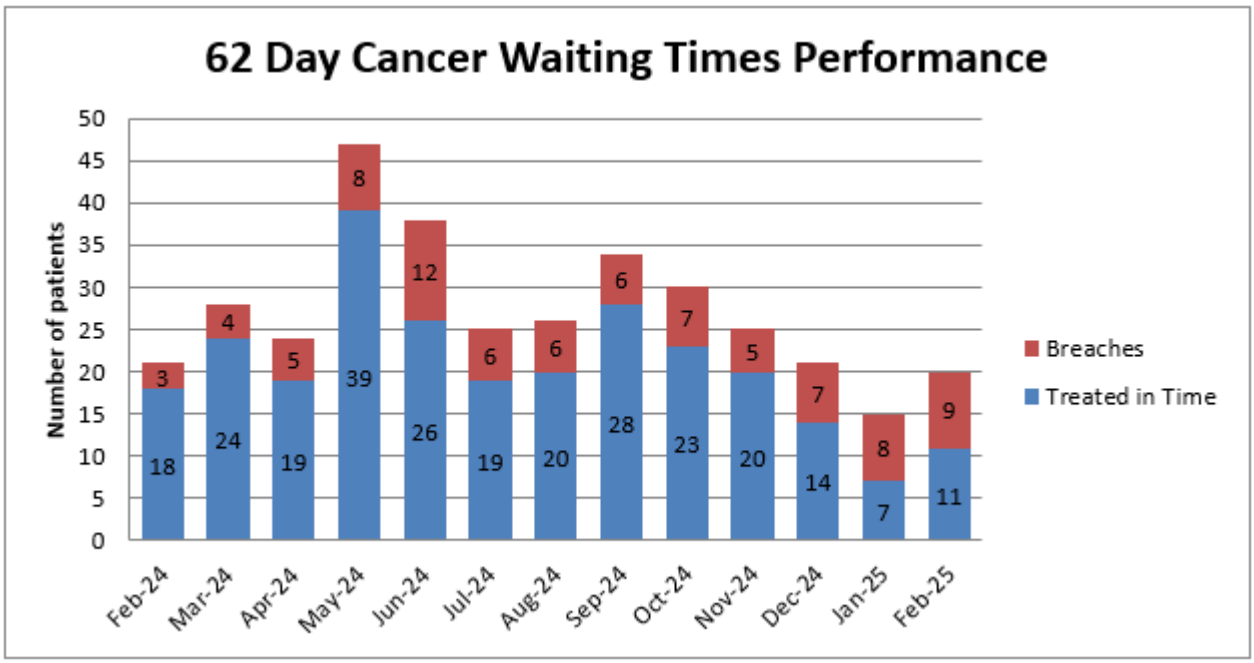
Cancer Waiting Times

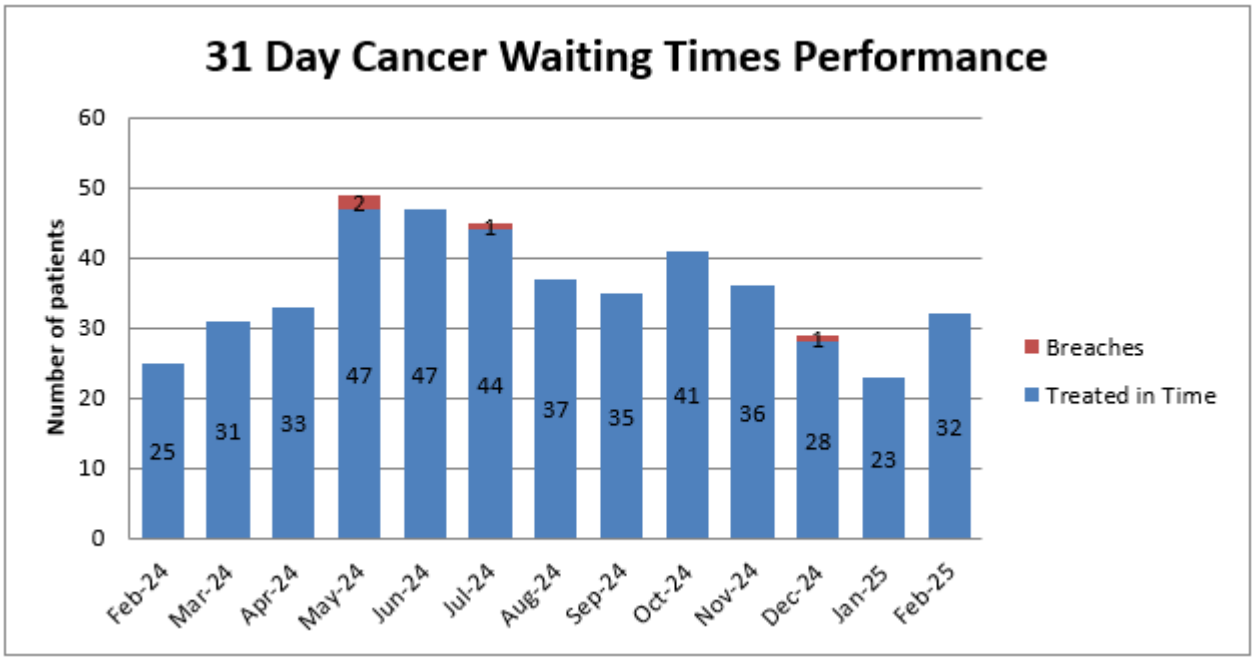




Please Note: There is a 1 month lag time for data.

Target Line 95% Target 99% Limits





Performance:

During the month of February 2025, performance against the 62-day standard was 55% and against the 31-day standard was 100%.

Nine patients breached the 62-day target during February:

- Six Prostate patients breached due to delays in the local diagnostic pathway related to waits for Prostate Biopsy and MRI scans.
- Two Breast patients breached due to long wait for first appointment.
- One Colorectal patient breached due to long wait for initial Colonoscopy.

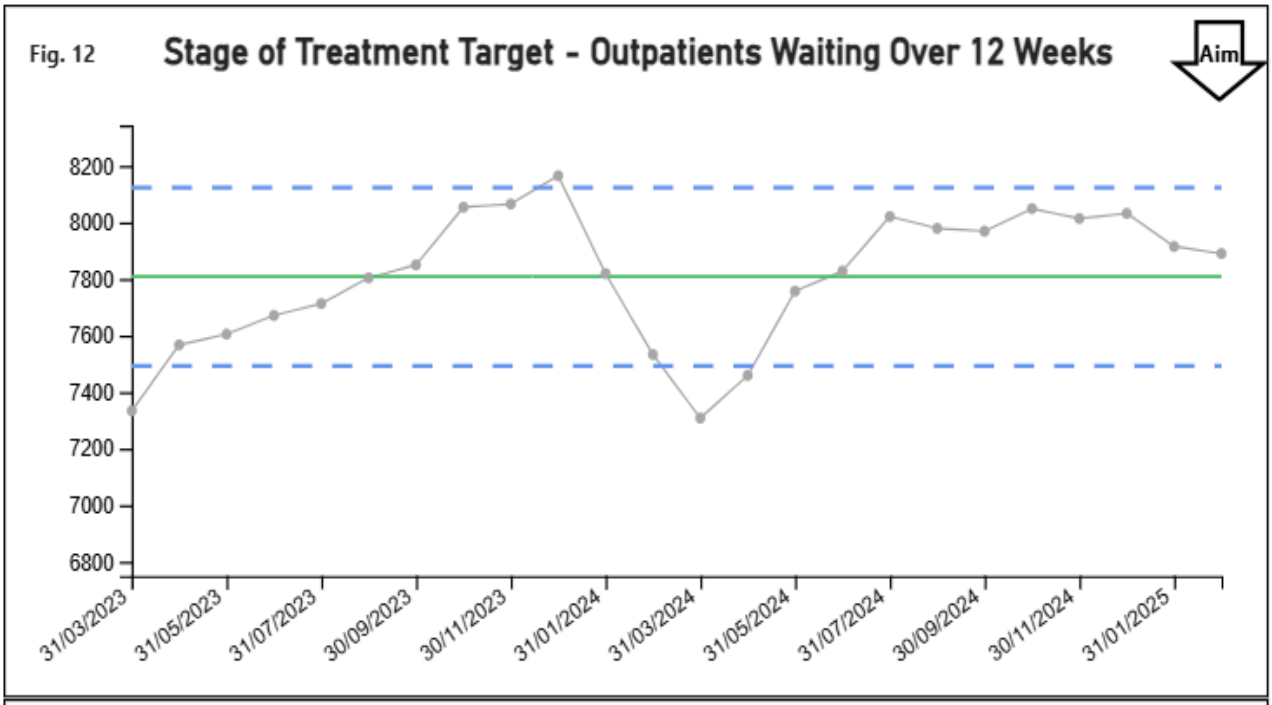
Other Issues:

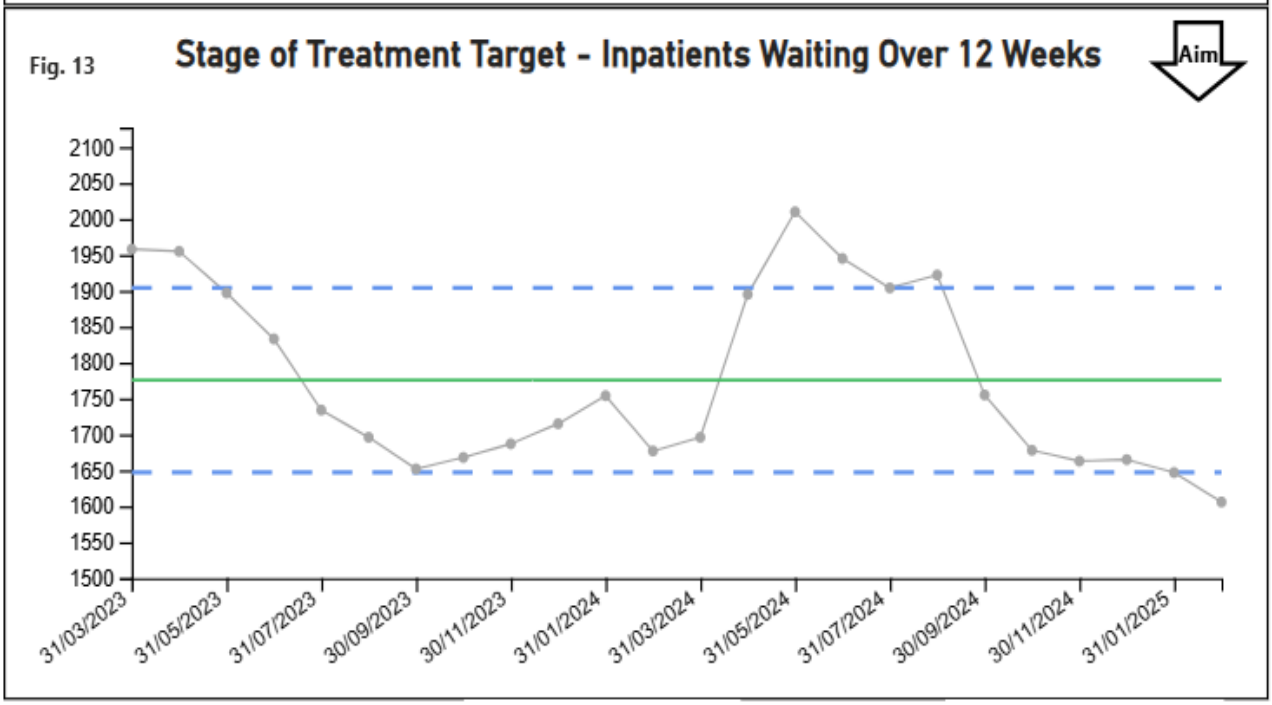
- The Prostate pathway remains the most significant risk, with considerable delays around biopsy and other diagnostic steps. These waits have been exacerbated by a significantly increased number of referrals and a number of patients will continue to be reported as breaches over the coming months due to the continuing delays.
- Breast clinic waits were problematic over the Christmas period, and this resulted in the two breaches detailed above. Waiting times have now improved following additional clinics provided by the Forth Valley clinical team.
- Bowel Screening Colonoscopy and Colonoscopy waits are increasing following the return to previous arrangements for weekend activity, and changes to booking processes. A new Nurse Colonoscopist has taken up post and is expected to be able to work independently by the end of 2025, however currently the waiting times for bowel screening colonoscopy are around 6-7 weeks. This has been escalated with service management.
- Waiting times for initial outpatient appointments are an ongoing issue, and we are beginning to see breaches as a direct result of these. This issue has been escalated, and clinic templates will be reviewed to ensure that there is sufficient capacity for these patients to be seen timeously.

Actions:

- The refreshed Framework for Effective Cancer Management has been issued by Scottish Government; this is being reviewed for local compliance and improvement opportunities following participation in national Dynamic Tracking and Escalation workshops.
- Improvement work around the Prostate pathway is ongoing and a new Task and Finish Group led by Interim Director of Acute Services has been initiated.
- Weekend Colonoscopy lists and additional mobile Radiology capacity have been extended to April 2025 until waiting times funding is confirmed for the full financial year.
- Breast clinic capacity is being reviewed by the local service to reduce dependency on the Forth Valley team to deliver clinics in Borders.
- Demand and capacity analysis is being undertaken around outpatient referrals and clinics to ensure that there is sufficient capacity available for patients to have first appointments timeously.

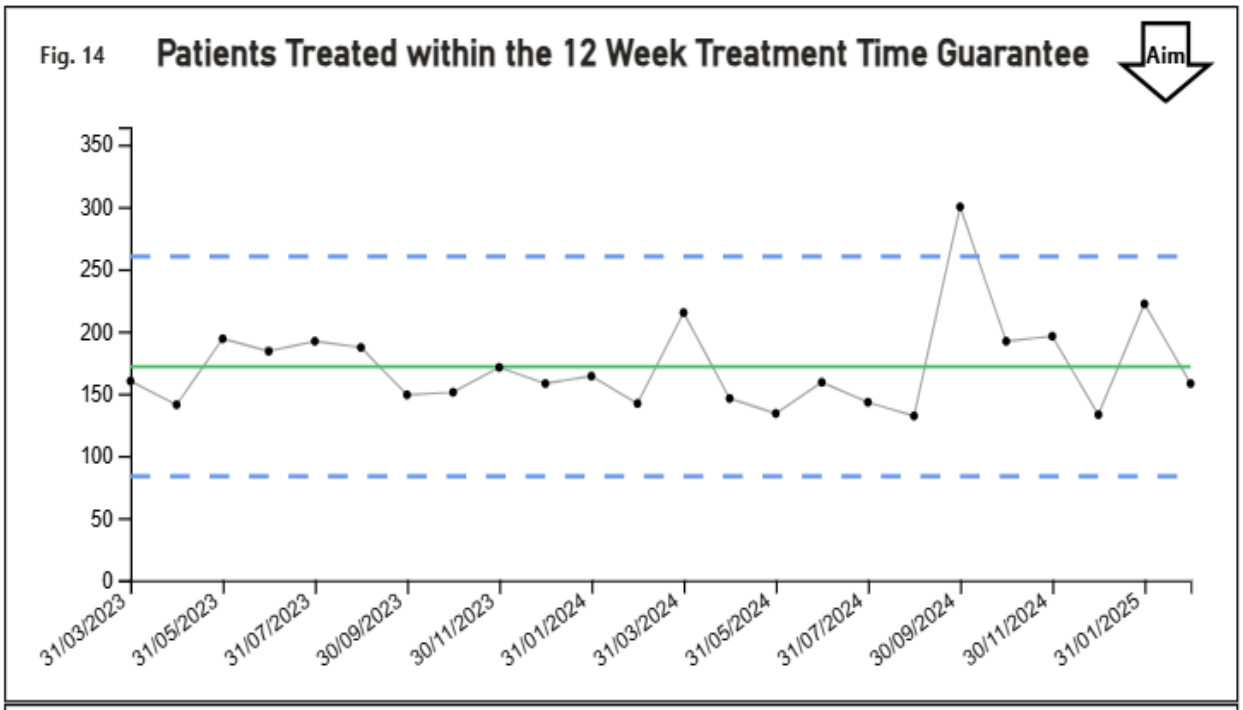
Stage of Treatment- Outpatients/Inpatients waiting over 12 weeks

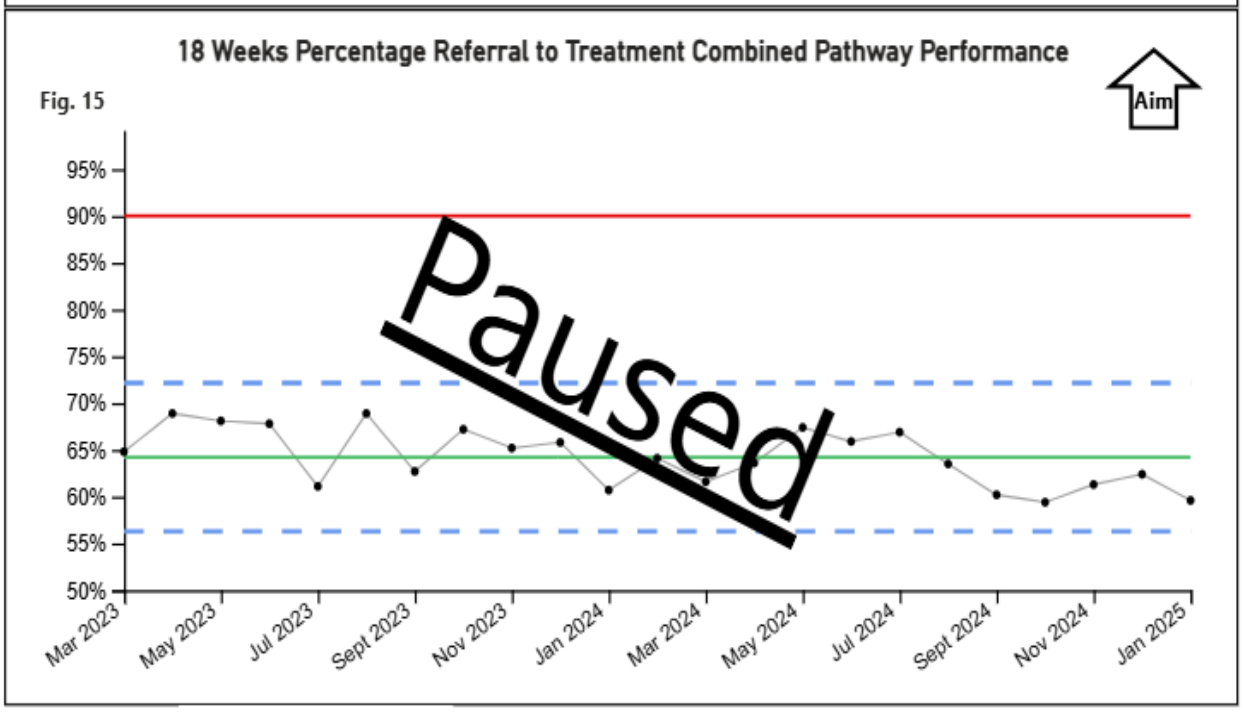




Target Line — 90% Target — 99% Limits - - -

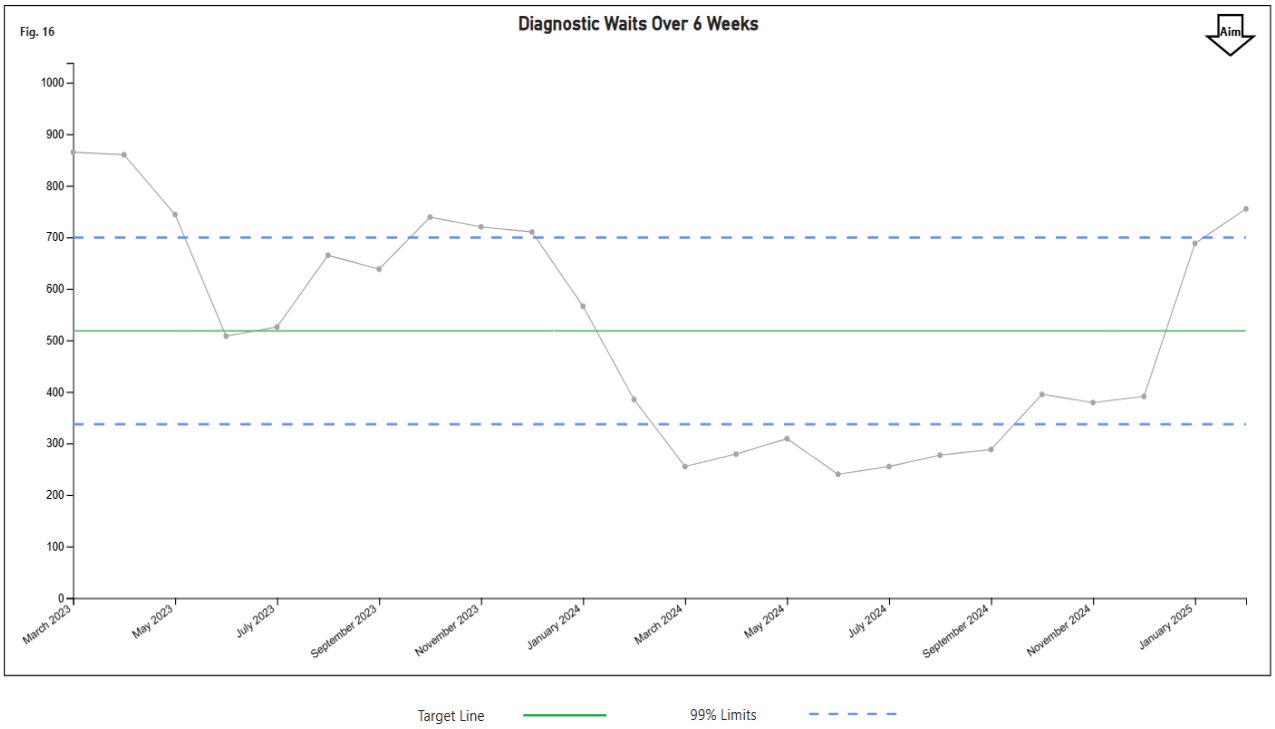
Treatment times



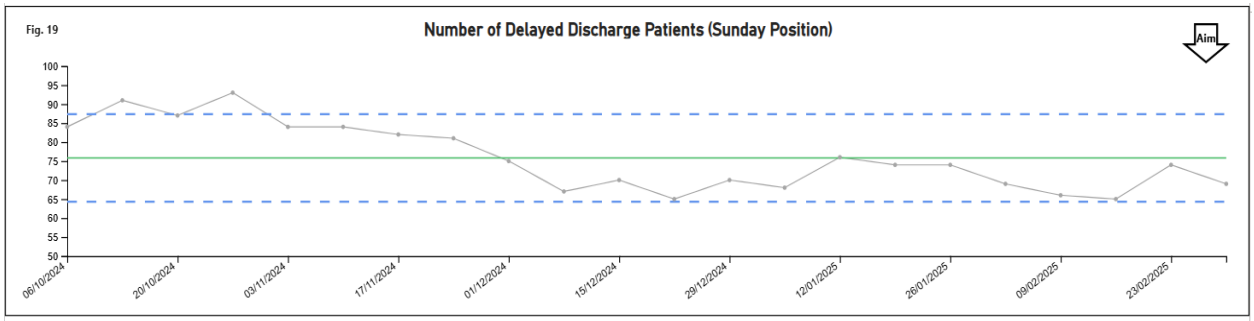


Target Line — 90% Target — 99% Limits

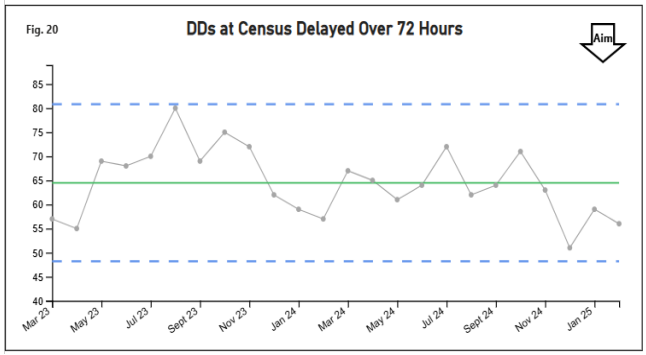
Diagnostic Waits

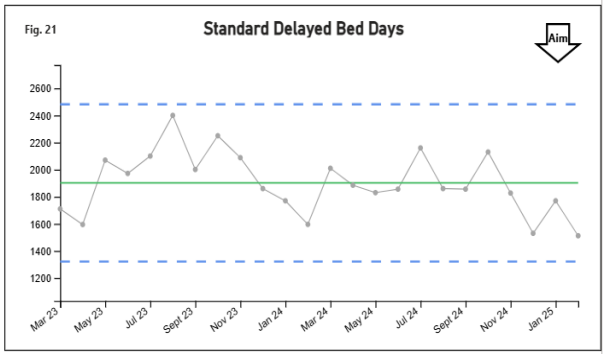


Delayed Discharges



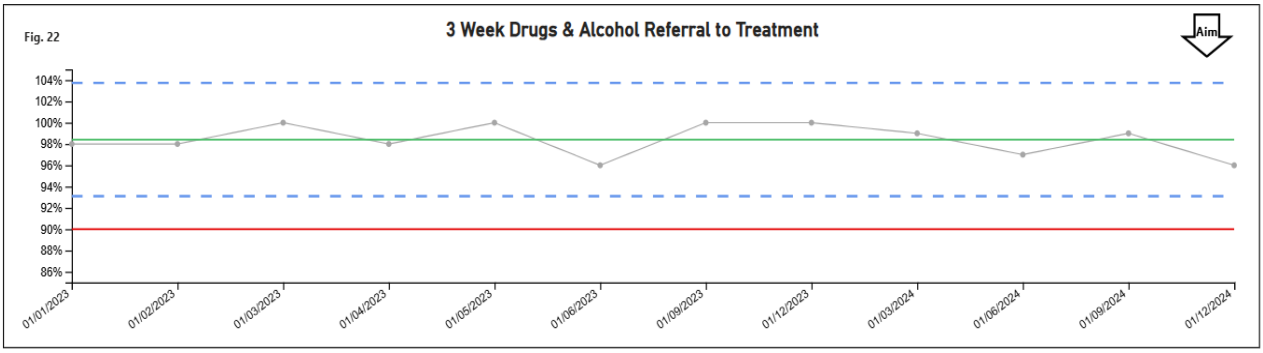
Target Line — 99% Limits





Drugs & Alcohol

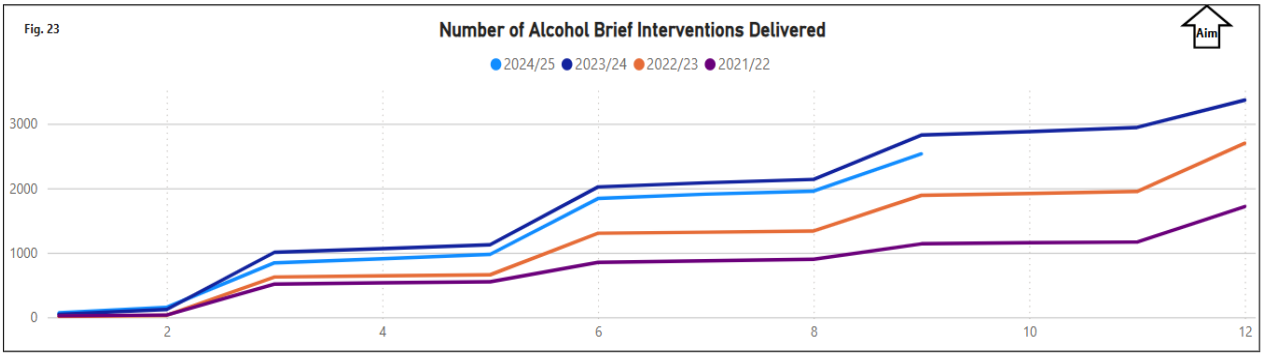
Fig. 22



Note: Updates provided Quarterly

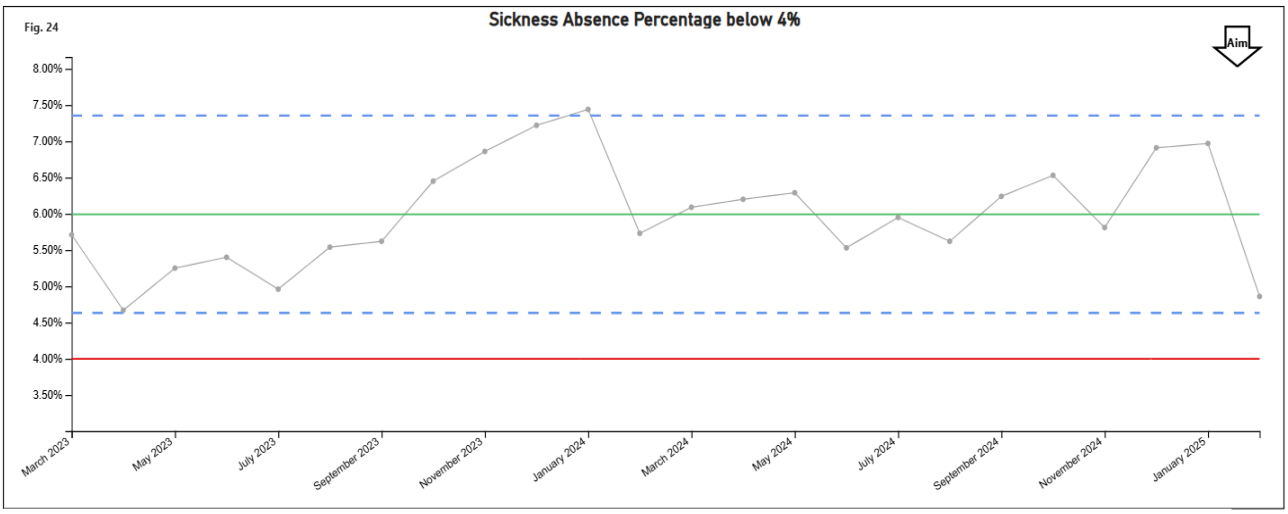
Target Line — 90% Target — 99% Limits

Fig. 23



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.

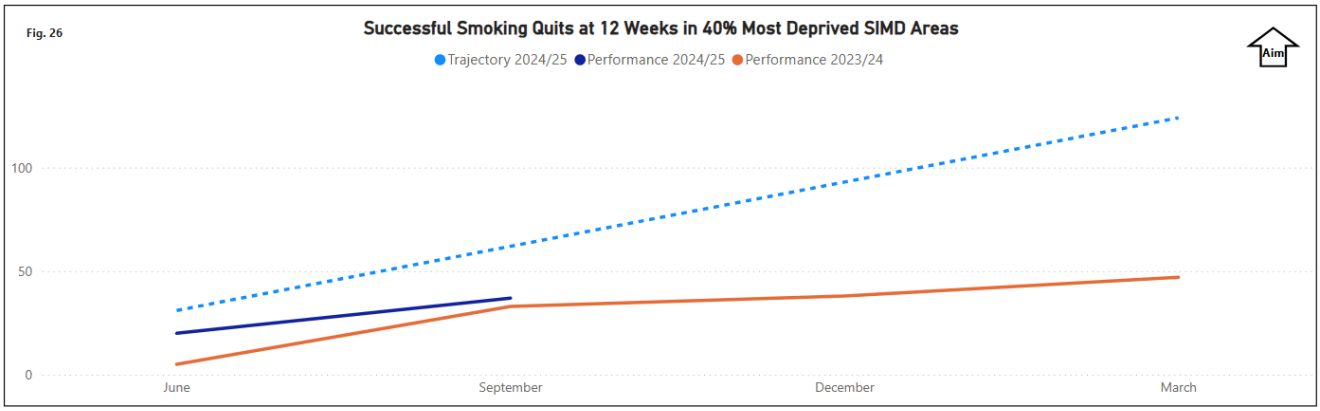
Sickness Absence



Note: Sickness absence data does not includes any COVID-19 related absences.

Target Line — 4% Target — 99% Limits

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)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 April 2025**
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 19 March 2025

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, Integration Joint Board minutes 20.11.24
- Appendix No 2, Integration Joint Board minutes 22.01.25

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 20 November 2024** at **10am** as a hybrid meeting in the Council Chamber, Scottish Borders Council and via Microsoft Teams

Present:

(v) Cllr D Parker
(v) Cllr R Tatler
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicoll
(v) Mrs L O'Leary, Non-Executive(Chair)
(v) Mrs K Hamilton, Non-Executive
(v) Mr J Ayling, Non-Executive
(v) Mrs F Sandford, Non-Executive
(v) Mr J McLaren, Non-Executive
Mr C Myers, Chief Officer
Mrs L Turner, Interim Chief Financial Officer
Dr L McCallum, Medical Director
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Ms L Gallacher, Borders Carers Centre
Ms L Jackson, LGBTQ+
Mr D Bell, Staff Side, SBC
Ms V MacPherson, Partnership Rep, NHS Borders
Ms J Amaral, Chief Executive, Borders Community Action
Mr N Istephan, Chief Executive, Eildon Housing Association

In Attendance:

Miss I Bishop, Board Secretary
Mr D Robertson, Chief Executive, Scottish Borders Council
Mr P Moore, Chief Executive, NHS Borders
Mrs J Stacey, Chief Internal Auditor
Dr S Bhatti, Director of Public Health, NHS Borders
Mrs L Huckerby, Director of Acute Services
Mrs L Jones, Director of Quality & Improvement
Mr A Carter, Director of HR, OD & OH&S, NHS Borders
Ms J Glen, Head of Adult Services
Mr M Fleming, Finance Manager, SBC
Ms S Laurie, Senior Communications Officer
Ms L Thomas, Communications Officer
Mr D Knox, Reporter BBC Scotland

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr N Richards, Elected Member, Mrs J Smith, Borders Care Voice, Mr A Bone, Director of Finance, Mr P Grieve, Chief Nurse Health & Social Care Partnership, and Dr R Mollart.

1.2 The Chair welcomed attendees and members of the public and press to the meeting.

1.3 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were 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 18 September 2024 were approved.

4. MATTERS ARISING

4.1 **Action 2024-11:** It was noted that the item had been postponed due to the coordinator postholder leaving the organisation.

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 Myers provided a presentation on the delivery report and highlighted several key elements of it including: General Practice out of hours; adult social work waiting lists; Child and Adolescent Mental Health referral to treatment; carer support plans; impact on unpaid carer health and wellbeing; discharge without delay; delayed discharge trajectory; and occupied bed days.

5.2 Discussion focused on: standardisation of best practice across social work services was yielding good performance; establishment of the “what matters hub” in Hawick enabled the signposting of people from the social work waiting list; CAMHS redesign of services to enable 12 new patients appointments a week; 9 months waits for those with neurodiversity who were treated as core CAMHS and for those with more significant issues prompt access to services was provided; challenges in terms of vacancies and short notice sickness absence due to stress and anxiety; 91% discharge without delay was to be commended however it was recognised that harm would be caused to the 9% who remained delayed; progress was poor in relation to the moving on policy and needed to be addressed; variability in processes required to be addressed; occupied bed days by individual; measure things differently in future to enable complete transparency across the system; A&E attendance numbers; progress with the succinct easy read version of reports for the public; the data lag caused by national data delays; and the work that was underway with the strategic risk register review.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Delivery Report.

6. DIRECTION: HEALTH AND SOCIAL CARE WINTER PLANNING

6.1 Mrs Lynne Huckerby provided a presentation on winter planning and covered several elements including: winter planning timeline and business continuity exercise; staff winter engagement; winter roadshows drop in sessions and themes and feedback received; model of care aligned to our communications approach; acute bed modelling to create additional capacity during the winter period (15 beds); forecast bed demand; produce and launch our healthcare leaflet.

6.2 Mr Chris Myers spoke to several slides in relation to winter actions around fuel and food support to those most at risk/in need.

6.3 Mrs Juliana Amaral spoke of the integration of warm spaces, financial inclusion, citizen advice bureau advisers and outreach services.

6.4 Discussion focused on: engagement exercise; citizens advice bureau funding for those as risk of disconnection or wider; where was the wider winter plan across the whole partnership; single point of contact for the vulnerable at winter; funding to reduce social isolation, loneliness, providing warm spaces, hot food, time for a blether and biscuit; public expectation and behaviour; what were the outcomes from discharge without delay and could it be sustained; kaizen approach and triage within the Emergency Department; important for all to promote the pension credit scheme; evaluation of last years warm and well fund; and maximising the use of the voluntary sector whilst investing in existing services;

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to issue the direction to direct NHS Borders and Scottish Borders Council to deliver the Winter plan as outlined in the IJB papers to improve outcomes over winter. The plan needed to be underpinned by effective joint communications from the communications teams in NHS Borders and the Scottish Borders Council, which needed to be single and easy to read and along with the support of non statutory partners. In addition the IJB directed its partners to continue with its focus to reduce the number of people waiting for care in hospital as delayed discharges.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to support the delegation of authority to a small group to include IJB members, to see how to maximise those outcomes of the warm and well fund to make sure the £30k was maximised.

7. QUARTER 2 UPDATE AND 2025/26 FORWARD PLAN

7.1 Mrs Lizzie Turner provided an overview of the Quarter 2 update and highlighted several key points including: overall pressure of £374k; underlying pressures and additional support from NHS Borders of £8.8m and £6.2m set aside which would present as an on-going financial challenge in future years; the payment offer; increase in delegated budgets due to technical adjustments in Scottish Borders Council (SBC) and NHS Borders; expected in year savings; set aside forecasting; carers act funding was fully

committed; savings target forecast; hospital at home funding; and that reserves would continue to be drawn down.

7.2 Discussion focused on: the fluctuation in reserves due to allocations from the Scottish Government; Hospital at Home was a 2 year project; Carers Act breakdown of funds across Aberlour and respite services; and a technical adjustment for the prescribing transfer.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the financial position of the IJB as at 30th September 2024.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the continued risk to the financial sustainability of the IJB due to current funding levels compared to running costs and anticipated demand.

8. 25/26 FUTURE PLAN

8.1 Mrs Lizzie Turner provided an update on progress and advised that a high level financial plan was being worked on and would contain deadlines and timelines. A 5 year plan was being worked up and a payment letter to both NHS Borders and SBC was being finalised for release. She was keen to understand the partners processes so that a more cohesive picture could be seen earlier in the financial year and she would request indicative payment letters to assist with planning processes.

8.2 Mrs Turner highlighted that Scottish Government funding was expected to be confirmed to NHS Borders and SBC in early December which would feed into the respective partners financial processes and then into the IJB financial process. She was aware that the Scottish Government had not confirmed the NHS planning timetable and suggested that any delay would affect the IJB timelines.

8.3 Mrs Turner further commented that work was ongoing in regard to feeding the Buchan and Associated work into the financial plan. NHS Borders was planning for a 10% reduction over 3 years and SBC had identified areas of priority spend. Further work was required to be taken forward on the integration of management structures and how IT systems could support that. A new NHS Borders strategy was underway and detailed planning would change over time as more information came to light and would be reflected in the IJB medium term plan.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update.

9. AGE FRIENDLY COMMUNITIES

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the item had been postponed.

10. PCIP ANNUAL REPORT

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the PCIP Annual Report

11. STRATEGIC PLANNING GROUP MINUTES 21 AUGUST 2024, 10 SEPTEMBER 2024

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

12. ANY OTHER BUSINESS

12.1 No further business was raised.

13. DATE AND TIME OF NEXT MEETING

13.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 22 January 2025, from 10am to 12 noon through MS Teams and in person in the Council Chamber, Scottish Borders Council.

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 22 January 2025** at **10am** as a hybrid meeting in the Council Chamber, Scottish Borders Council and via Microsoft Teams

Present:

(v) Cllr D Parker
(v) Cllr N Richards
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicoll
(v) Mrs L O'Leary, Non-Executive(Chair)
(v) Mrs K Hamilton, Non-Executive
(v) Mr J Ayling, Non-Executive
(v) Mr J McLaren, Non-Executive
Mr C Myers, Chief Officer
Mrs L Turner, Chief Financial Officer
Dr L McCallum, Medical Director
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Ms D Rutherford, Borders Carers Centre
Mrs J Smith, Borders Care Voice
Ms L Jackson, LGBTQ+
Mr D Bell, Staff Side, SBC
Ms J Amaral, Chief Executive, Borders Community Action
Mr N Istephan, Chief Executive, Eildon Housing Association

In Attendance:

Miss I Bishop, Board Secretary
Mr P Moore, Chief Executive, NHS Borders
Mr A Bone, Director of Finance,
Mr P Grieve, Chief Nurse Health & Social Care Partnership
Mrs J Stacey, Chief Internal Auditor
Dr S Bhatti, Director of Public Health, NHS Borders
Mrs L Jones, Director of Quality & Improvement
Ms J Glen, Head of Adult Services
Mr M Fleming, Finance Manager, SBC
Mr A Medley
Mrs C Oliver, Head of Communications, NHS Borders
Mr D Knox, Reporter BBC Scotland

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr R Tatler, Elected Member, Mrs F Sandford, Non-Executive, Ms L Gallacher, Borders Carers Centre and Mr A Carter, Director of HR, OD & OH&S, NHS Borders.

1.2 The Chair welcomed attendees and members of the public and press to the meeting, including Ms D Rutherford to the meeting who was deputising for Ms L Gallacher.

1.3 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none declared.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting were not available due to sickness absence and would be presented to the next meeting for approval.

4. MATTERS ARISING

4.1 The action tracker was not available due to sickness absence and would be presented to the next meeting for noting.

5. HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE AND DELIVERY REPORT

5.1 Mr Chris Myers provided an overview of the content of the report and highlighted several elements including: general practice activity levels; what matters hubs; adult social work waiting lists; home care need; child and adolescent mental health service (CAMHS) waiting times; vaccination rates; delayed discharges; movement to home care services; Promoting Care Positive Award Employer Status to embed better support to unpaid carers across the Borders with all partners; commissioned the review of health and social care capacity through Buchan Associates and an expectation that work would complete the next month and it would form part of the commissioning plan for 2025/26; winter plan actions that were commissioned were being progressed; and the warm and well initiative.

5.2 A discussion ensued which focused on several elements including: social care capacity; holding high risk in the Emergency Department; supporting staff to deliver the best care possible; step change approach to reduce pressure in the system; continued ring fencing of £30k for the warm and well scheme; prevention and early interventions; GP hours and any learning of good practice that GPs might share between them; vaccinations uptake; workforce challenges and impending national insurance employer contributions; data to show that the patient experience of local GPs is positive; working in partnership with care providers; and an appreciation of the clear breakdown of data on delayed discharges within the report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Delivery Report.

6. IJB ANNUAL ACCOUNTS 2023-24

6.1 Mrs Lizzie Turner presented the IJB Annual Accounts for 2023/24 and advised that an unqualified opinion had been received from the external auditors. She commented that

there was significant improvement for the period 2024/25 and 2 new recommendations were given on the delivery of the medium term plan and a review of best value arrangements to be undertaken in 2025/26. There had also been a small change to the remuneration report within the Accounts. The Accounts themselves were similar to those for 2022/23 with a £4.5m overspend, which the relevant partner would address. Mrs Turner also referred to the overspend on prescribing, high cost of out of areas placements and the underspend in SBC services due to vacancies in social care services. The set aside figure in the accounts was £3.6m which accounted for pressures in the Emergency Department and unmet savings targets and the IJB reserve of £9.8m had reduced to £6.8m.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** reviewed the final audited IJB Annual Accounts for 2023/24 and approved them for signature.

7. AUDIT SCOTLAND ANNUAL AUDIT REPORT

7.1 Mrs Lizzie Turner presented the report for noting.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the Audit Scotland Annual Audit Report.

8. DIRECTION: TWEEDBANK CARE VILLAGE REVENUE CASE

8.1 Ms Julie Glen provided an overview of the content of the report and recommended direction. She highlighted several elements including: capital costs; revenue business case costs; community consultation; improved health and wellbeing outcomes; additional capacity for beds; social care and health staff transfer from Garden View into the new Care Village; and building maintenance costs.

8.2 Discussion focused on: involving the wider community as both service users and as volunteers; looking to the future to reinvigorate volunteering opportunities in NHS Borders; adult changing facility design and availability; there were no revenue costs associated with the proposal; clinical engagement; where would he return on investment be notwithstanding the positive benefits for individuals; potential for income generation and sponsorship; promoting independence for individuals with a focus on reablement; embedding the discharge to assess approach in the community; potential for central area day services to be delivered from the care village; equity for the breadth of the population in the Scottish Borders not just centrally; ties into Buchan and Associates work; in terms of staffing resource there will be a need to focus on nursing and AHPs as there would likely be a potential for additionality; and hesitation on the health care component going forward without additional revenue.

8.3 The Chair suggested issuing the direction and in executing it to make sure it looked at capacity projections, revenue projections and demand income generation.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the proposed model of care and staffing model set out in the report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the associated revenue spend.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed any profits generated by the Social Enterprises are reinvested into the care village as set out within the report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed that the existing funding from SBC and NHS Borders currently allocated to Garden View and Waverley be transferred to the Tweedbank Care Village in its entirety.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** directed Scottish Borders Council and NHS Borders to deliver in line with the revenue business case with the caveat that in issuing the direction and in executing it to make sure it looked at capacity projections, revenue projections and demand income generation.

9. FINANCIAL PLANNING 2025-26

9.1 Mrs Lizzie Turner provided an overview of the content of the report and highlighted that both financial planning processes were on-going in SBC and NHS Borders. She drew the attention of the Board to the release of the payment letter in December to both partner organisations and that both organisations were working on their responses. The Scottish Government had announced that NHS Borders would receive a 3% uplift to their general allocation and that moving forward brokerage would not be available to health boards, and that was something that the health board would need to consider on the basis of the additional payment made to the IJB in 2024/25 in order for it to breakeven. SBC would receive £19m of additional funding and £15m had been committed. She fully expected additional funding for ring fenced initiatives to be made available to the IJB via the NHS or Local Authority as the year progressed.

9.2 Mrs Turner advised that work was progressing on the 5 year plan and highlighted the significant risks in terms of prescribing costs and the impact of the national insurance employers cost increase.

9.3 Discussion focused on brokerage from NHS Borders for 2025/26 as per the requirement of the Scheme of Integration.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD BOARD** noted the progress made toward the delivery of the 2025/26 Financial Plan.

10. STRATEGIC RISK REGISTER UPDATE

10.1 Mrs Jill Stacey provided an overview of the content of the report and highlighted some of the risk factors and mitigations in place.

10.2 Discussion focused on: financial risk elements; decision making dependent on the quality of the data available; quarterly conversations on risk; and IJB strategic framework.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the work in progress to manage the IJB Strategic Risk Register.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further risk update will be provided in alignment with the relevant progress updates on the Delivery Plan in 2025.

11. STRATEGIC PLANNING GROUP MINUTES 13 NOVEMBER 2024

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

12. ANY OTHER BUSINESS

12.1 No further business was raised.

13. DATE AND TIME OF NEXT MEETING

13.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 19 March 2025, 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:	**3 April 2025**
Title:	**Board Committee Memberships**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Person Centred

2 Report summary

2.1 Situation

It is good practice for Non Executives to be exposed to the full range of Committees that service the Board and as part of the annual Appraisal process for Non Executives, the Chair discusses with them the range of Committees they service.

This report provides an update to the changes in Board memberships since those agreed by the Board on 5 December 2024.

- In February 2024 Mr Tris Taylor resigned as a Non Executive Director and the Board has continued to operate with that Non Executive vacancy. Changes were made to quoracy numbers on committees to enable any impact on Non Executives workload to be mitigated where possible.

- It is proposed that the Board continue to operate with one Non Executive vacancy which will continue to contribute to the savings target of the Board.

- In January 2025 Dr Kevin Buchan resigned as a Stakeholder Non Executive Director (ACF Chair).

- An election process is in place to elect a new ACF Chair who will become a Stakeholder Non Executive Director of the Board.

- On 4 April 2025 Mrs Harriet Campbell will conclude her appointment as a Non Executive Director.

- A recruitment process for a new Non Executive to join the Board is underway jointly with NHS Highland.

- Mr John McLaren has been reappointed for a fourth term as Chair of the APF (Stakeholder Non Executive) with effect from 01.04.25.

- From 1 April 2025 the Chair and Vice Chair roles of the Integration Joint Board will rotate for the next 3 year period. Cllr D Parker will become Chair of the IJB and Mrs Lucy O'Leary will become Vice Chair of the IJB and Chair of the Strategic Planning Group.

- The Chair will leave the membership of the Children & Young Peoples Partnership Board (CYPP).

- Mr James Ayling will join as a member of the Children & Young Peoples Partnership Board.

- The membership of the Learning Disability and Mental Health Partnership Boards are currently under review

- Mrs Harriet Campbell also held the portfolio of "Sustainability Champion" which will become vacant.

- Mrs Harriet Campbell will continue as the Chair of the Organ Donation Committee in her capacity as a member of the public.

- The Area Drugs and Therapeutics Committee terms of reference are being reviewed to clarify the requirement of the ACF Chair to chair that committee.

2.2 Background

In line with the Code of Corporate Governance the Board must approve the Non Executive membership, including the appointment of Chairs and Vice Chairs as appropriate, of its Committees.

2.3 Assessment

This report provides an update to the changes in Board memberships since those agreed by the Board on 5 December 2024.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Committees are created as required by statute, guidance, regulation and Ministerial direction and to ensure efficient and effective governance of the Boards' business.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This report has been produced for the Board.

2.4 Recommendation

The Board is asked to **note** the changes in Non Executive memberships of its Committees as set out in the NHS Borders Non Executives Committee Chart (Appendix 1).

The Board is asked to **confirm** that it will continue to operate with one Non Executive vacancy for the period 2025/26 which will continue to contribute to the savings target of the Board.

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, NHS Borders Non Executives Committee Chart.

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2025 – 27.03.2025

Name/Cttee	Vacant (Hold for savings)	John McLaren (APF)	Fiona Sandford (Vice Chair)	Karen Hamilton Chair	Vacant (ACF)	Lucy O'Leary (Digital Champion)	Cllr David Parker (LA)	Lynne Livesey (Whistle-blowing Champion)	Vacant (Sustainability Champion)	James Ayling	Exec Lead & Secretariat
Borders NHS Board (All NEDs) (Quoracy 1/3 all members)		**X**	**VC**	**C**	**X**	**X**	**X**	**X**	**X**	**X**	CEO BS
GOVERNANCE											
Resources & Performance Committee (All NEDs) (Quoracy 2 NEDs)		**X**	**X**	**C**	**X**	**X**	**X**	**X**	**X**	**X**	CEO BS
Audit & Risk Committee (4 NEDs) (Quoracy 2 NEDs)						**X**	**X**	**X**		**C**	DoF DoF PA
Clinical Governance Committee (4 NEDs) (Quoracy 2 NEDs)			**C**		**X**			**X**	**X**		DoQI CG&Q PA
Staff Governance Committee (4 NEDs) (Quoracy 2 NEDs)		**X**					**C**	**X**	**X**		DHR DHR PA
Remuneration Committee (5 NEDs) (Quoracy 3 NEDs)		**X**	**X**	**C**					**X**	**X**	DHR BS
Area Clinical Forum (Chair ACF) (Quoracy 1/3 all members)					**C**						ACF Chair CEO PA
PARTNERSHIP											
Area Partnership Forum (Chair APF) Quoracy 5 x Management, 5 x Staff Side)		**C**									ED ED PA
Community Planning Partnership Strategic Board (Chair & Vice Chair)			**X**	**X**							SBC
CYPPP Board (1 NED)										**X**	SBC
Police, Fire & Rescue & Safer Communities Board (1 NED)										**X**	SBC

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2025 – 27.03.2025

Name/Cttee	**Vacant** (Hold for savings)	**John McLaren** (APF)	**Fiona Sandford** (Vice Chair)	**Karen Hamilton** Chair	**Vacant** (ACF)	**Lucy O'Leary** (Digital Champion)	**Cllr David Parker** (LA)	**Lynne Livesey** (Whistle-blowing Champion)	**Vacant** (Sustainability Champion)	**James Ayling**	**Exec Lead & Secretariat**
OTHERS											
Endowment Fund Board of Trustees (All NEDs)		**X**	**X**	**C**	**X**	**X**	**X**	**X**	**X**	**X**	DoF DoF PA
Expert Advisory Group to Endowment Cttee (4 NEDs)	**X**	**C**		**X**	**X**						DoP&P DoP&P PA
Area Drugs & Therapeutics Cttee (ACF Chair)					**C**						DoP DoP PA
Car Park Appeals Panel (1 NED)		**C**									GSM GSM
Values Based Healthcare					**X**					**X**	MD PA
Whistleblowing Champion								**X**			Scot Gov't
Sustainability Champion									**X**		Scot Gov't
Digital Champion						**X**					Scot Gov't
OCCASIONAL/AS AND WHEN NECESSARY											
Discretionary Points Committee (Annual)			**C**								DHR DDHR
Pharmacy Practices Committee				**C**							MD DoP PA
Dental Appeals Panel (1 NED required at the final escalation stage only)											MD MD PA
ECR Panels (1 NED required at the final escalation stage only)											MD DPH PA
Dismissal Appeal Hearings (1 NED required on all dismissal appeal hearings as per NHSS Formal Hearing Guide)											DHR DDHR
LINKAGES											
Area Clinical Forum			**A**								ACF Chair CEO PA
Mental Health Partnership										**A**	GM MH&LD

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2025 – 27.03.2025

Name/Cttee	**Vacant** (Hold for savings)	**John McLaren** (APF)	**Fiona Sandford** (Vice Chair)	**Karen Hamilton** Chair	**Vacant** (ACF)	**Lucy O'Leary** (Digital Champion)	**Cllr David Parker** (LA)	**Lynne Livesey** (Whistle-blowing Champion)	**Vacant** (Sustainability Champion)	**James Ayling**	**Exec Lead & Secretariat**
Board											PA
Learning Disability Partnership Board						**A**					GM MH&LD PA
Organ Donation Committee (Chaired by Harriet Campbell, as a member of the public)											Hospital Management
TOTAL	**1**	**8**	**8**	**7**	**8**	**7**	**5**	**8**	**7**	**8**	

Changes highlighted in pink.

KEY

C	Chair	DDHR	Deputy Director of HR
VC	Vice Chair	GSM	General Services Manager
X	Member	GM	General Manager
A	Attendee	DoME	Director of Medical Education
CEO	Chief Executive	SBC	Scottish Borders Council
DoF	Director of Finance	ED	Employee Director
DoNMA	Director of Nursing, Midwifery & AHPs	PA	Personal Assistant
DPH	Director of Public Health	CO H&SCI	Chief Officer Health & Social Care Integration
MD	Medical Director	DHR	Director of HR, OD & OH&S
DoQI	Director of Quality & Improvement	CG&Q	Clinical Governance & Quality
DoP&P	Director of Planning & Performance	DoP	Director of Pharmacy
BS	Board Secretary		

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2025 – 27.03.2025

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AND ASSOCIATED COMMITTEES

Name/Cttee	Vacant	John McLaren (APF)	Fiona Sandford (Vice Chair)	Karen Hamilton Chair	Vacant (ACF)	Lucy O'Leary (Digital Champion) **(IJB Vice Chair 2025-28)**	Cllr David Parker (LA) **(IJB Chair 2025-28)**	Lynne Livesey (Whistle-blowing Champion)	Vacant (Sustain-ability Champion)	James Ayling	Exec Lead & Secretariat
Scottish Borders Health & Social Care Integration Joint Board (H&SC IJB) (5 NEDs Required)		**XV**	**XV**	**XV**		**VC-XV**	**C** (Appointed in capacity as a Cllr)			**XV**	**IJB CO BS**
H&SC IJB Audit Committee (2 NEDs Required)				**XV**		**XV**					**IJB CFO BS**
H&SC IJB Strategic Planning Group **(Vice Chair of IJB, Chairs the SPG)**						**C**					**IJB CO PA**
TOTAL	**0**	**1**	**1**	**2**	**0**	**3**	**1**	**0**	**0**	**1**	

Changes highlighted in pink.

KEY

C	Chair
VC	Vice Chair
XV	Member (Voting)
XNV	Member (Non Voting)
BS	Board Secretary
IJB CO	Integration Joint Board Chief Officer
IJB CFO	Integration Joint Board Chief Financial Officer
PA	Personal Assistant