Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 2 April 2026** at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.01	**2**	**REGISTER OF INTERESTS**	Chair	*Appendix-2026-15*
10.02	**3**	**MINUTES OF PREVIOUS MEETING** 05.02.26	Chair	*Attached*
10.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
10.05	**5**	**CHIEF EXECUTIVE'S REPORT**	Chief Executive	*Appendix-2026-16*
10.10	**6**	**STRATEGY**		
	6.1	NHS Borders Deliverables Update	Chief Executive	*Appendix-2026-17*
	6.2	NHS Borders Anti Racism Plan	Director of People & Culture	*Appendix-2026-18*
10.35	**7**	**FINANCE AND RISK ASSURANCE**		
	7.1	Resources & Performance Committee minutes: 15.01.26, 05.03.26	Chair R&PC	*Appendix-2026-19*
	7.2	Audit & Risk Committee minutes: 15.12.25	Chair A&RC	*Appendix-2026-20*
	7.3	Finance Report	Director of Finance	*Appendix-2026-21*
	7.4	Risk Appetite Policy	Director of Quality & Improvement	*Appendix-2026-22*
10.55	**8**	**QUALITY AND SAFETY ASSURANCE**		
	8.1	Clinical Governance Committee minutes: 14.01.26	Chair CGC	*Appendix-2026-23*
	8.2	Quality & Clinical Governance Report	Director of Quality & Improvement	*Appendix-2026-24*

	8.3	Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	*Appendix-2026-25*
	8.4	Health & Care (Staffing) (Scotland) Act 2019 - Annual Report	Director of Nursing, Midwifery & AHPs	*Appendix-2026-26*
11.30	**9**	**ENGAGEMENT**		
	9.1	Staff Governance Committee minutes: 17.07.25, 16.12.25	Chair SGC	*Appendix-2026-27*
	9.2	Area Clinical Forum Minutes: 11.12.25	Chair ACF	*Appendix-2026-28*
	9.3	Whistleblowing Quarter 4 Report	Board Secretary	*Appendix-2026-29*
	9.4	Workforce Report	Director of People & Culture	*Verbal*
11.45	**10**	**PERFORMANCE ASSURANCE**		
	10.1	NHS Borders Performance Scorecard	Director of Planning & Performance	*Appendix-2026-30*
	10.2	Director of Public Health Annual Report	Director of Public Health	*Appendix-2026-31*
12.20	**11**	**GOVERNANCE**		
	11.1	Scottish Borders Health & Social Care Integration Joint Board minutes: 21.01.26	Chair IJB	*Appendix-2026-32*
	11.2	Code of Corporate Governance Sectional Refresh	Board Secretary	*Appendix-2026-33*
	11.3	Consultant Appointments	Director of People & Culture	*Appendix-2026-34*
12.29	**12**	**ANY OTHER BUSINESS**		
12.30	**13**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 25 June 2026 at 10.00am at Scottish Borders Council and via MS Teams	Chair	*Verbal*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Register of Interests**
Responsible Executive/Non-Executive:	**Fiona Sandford, Interim 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: 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 …26.03.2026……...

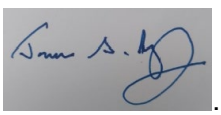
Borders NHS Board

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	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 ……10 March 2026……...

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	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.	
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	NIL
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	Member of Borders Samaritans

Signed……Lucy O'Leary…….. Date …21 Feb 2026……...

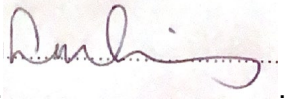
Borders NHS Board

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 Officer holders Qualifications and Assessment Committee RICS Members 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 …01.04.2026……...

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: JACQUELINE MARGARET PEPPER *(please insert your full name in capital letters)*

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	Employee of Perth & Kinross Council until 10/04/2026 which is my retirement date. This is a joint appointment with NHS Tayside. My public appointment with NHS Borders has been shared with my employer to ensure transparency and that any activity with NHS Borders between 05/01/2026 and 10/04/26 is undertaken in personal time and does not conflict with my contractual obligations.
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.	I am a volunteer Trustee of Children's Hospices Across Scotland (CHAS) a charity providing hospice and palliative care to children and their families in all areas of Scotland.

Signed…J Pepper…….. Date …05/01/2026……...

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 26 March 2026

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: …PAUL WILLIAMS ……. *(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.	

Signed……  …… Date …25.02.26……...

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: JOHN MCLAREN . *(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	Receive a band 7 salary as a Health Visitor and an honorarium for Non exec Role.
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.	Representative and Chair of Unite the Union NHS Borders Branch Registered on NMC

Signed  . Date 01/04/2026

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 …26.03.2026……...

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 ……18th February 2026……...

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 Lynn McCallum Date 26/5/26

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

Signed……Sohail Bhatti…….. Date …17th February, 2026……...

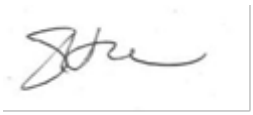
Borders NHS Board

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.	Member of Royal College of Nursing (RCN) Member of Royal College of Midwives (RCN)

Signed 

Date 18 February 2026

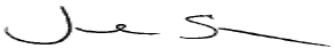
Borders NHS Board

Register of Interests of Board Members

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

Board Member: **JUNE SMYTH**

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

Signed:  Date: **03/03/2026**

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: AVRIL KEEN…….. *(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 ……... 24.02.26

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: **OLIVER BENNETT**

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 OB Date 18/2/26

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: GARETH CLINKSCALE *(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.	Member of *Managers in Partnership* trade union.

Signed  Date 24 February 2026

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…. Laura Jones Date 26/03/2026

Borders NHS Board

Minutes of the Borders NHS Board meeting held on Thursday, 2 February 2026 at 10.00am in the Business Suite, Scottish Borders Council and via MS Teams (Hybrid).

Present:
F Sandford, Interim Chair
L Livesey, Non Executive
J Ayling, Non Executive
L O'Leary, Non Executive
J Pepper, Non Executive
D Parker, Non Executive
P Moore, Chief Executive
A Bone, Director of Finance
S Horan, Director of Nursing, Midwifery & AHPs
S Bhatti, Director of Public Health

In Attendance:
I Bishop, Board Secretary
J Smyth, Director of Planning & Performance
O Bennett, Interim Director of Acute Services
G Clinkscale, Director of Acute Services
L Jones, Director of Quality & Improvement
S Whiting, Infection Control Manager
S Litster, Cancer Transformation Manager
H Jacks, Planning & Performance Officer
C Oliver, Head of Communications & Engagement
A Steele, District Nurse

1. Apologies and Announcements

1.1 Apologies had been received from L McCallum, Medical Director, J McLaren, Non Executive and P Williams, Non Executive.

1.2 The Chair welcomed J Pepper, Non Executive to her first meeting of the Board.

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

1.4 The Chair announced that two colleagues had been selected as finalists at the Royal College of Nursing (RCN) Scotland Nurse of the Year Awards 2026. K Bacon, ITU Clinical Nurse Educator, had been nominated for the Learning in Practice Award, while M Brownlee, Healthcare Support Worker, had been nominated for the Nursing Support Worker of the Year Award.

1.5 The Chair confirmed the meeting was quorate.

2. Declarations of Interests

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

The **BOARD** noted there were no declarations made.

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting of Borders NHS Board held on 4 December 2025 were amended at page 5, paragraph 8.1, line 5, to read "of how complex and difficult …" and with that amendment the minutes were approved.

4. Matters Arising

4.1 **Action 2025-4:** S Horan confirmed that the report had been submitted to the Staff Governance Committee and would be brought to the Board on 2 April 2026 to complete the action on the action tracker.

4.2 **Action 2025-5:** I Bishop confirmed that the revised APF ToR were part of the Sectional Refresh of the Code of Corporate Governance to be presented to the Audit and Risk Committee in March and then to the Board on 2 April for formal approval.

4.3 **Action 2025-6:** S Bhatti confirmed that progress had been made. A locum consultant had been appointed to lead the joint strategic needs assessment and undertake the option appraisal. Recruitment was also progressing to an epidemiology intelligence function and progress was being made liaising with Live Borders on the waiting well initiative and social prescribing service.

4.4 **Action 2025-7:** A Bone confirmed that cost avoidance reporting would be included in the next financial year and the Quarter 1 Report.

The **BOARD** noted the Action Tracker.

5. Chief Executive's Report

5.1 P Moore provided an overview of the content of the report and referred to the conclusion of the strategic work, the work that had been delivered the previous year and the rewiring of the organisation.

5.2 The Chair commented on the QI work that had been taken forward particularly in Theatres and the visit of C Lamb, Director General and Chief Executive NHS Scotland.

5.3 S Horan highlighted the state of play in regard to the reduced working week implementation from 1 April and the impact of that on the nursing workforce. She spoke of the work that had been progressed with Napier and alternative routes into education to bring people in the healthcare career sphere.

5.4 The Chair suggested adding the matter to the Action Tracker and asking P Moore to bring a paper to the Board in June which would focus on the provision of hours of care early in the treatment pathway instead of more interventions late on. She was keen the bring the lens of the innovative work of universities and colleges as well as

local initiatives, to see the whole picture in the round to be clear on the model of care the Board wished to deliver in the future.

The **BOARD** noted the report.

The **BOARD** agreed to receive a paper on Nursing Workforce and future delivery of services at the June Board meeting.

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

6. NHS Borders Cancer Strategy 2026-2033

6.1 O Bennett presented the revised NHS Borders cancer strategy and confirmed that it aligned to the new organisational and clinical strategies. S Litster talked through a presentation which provided the salient points of the caner strategy.

6.2 S Bhatti commented that it was a commendable piece of work and effectively addressed a gap in the clinical strategy, recognising that cancer was both a chronic and acute illness. He appreciated the balanced approach; however, he suggested a revision regarding the key commitments and suggested a more ambitious goal in regard to engaged communities. He recommended the measurement of impact by evaluating changes in people's behaviours aimed at reducing their cancer risk, as current evidence suggested health improvement activities yielded only marginal effects. O Bennet welcomed the suggestion and agreed to connect with S Bhatti outwith the meeting.

6.3 Further discussion focused on: increase in referrals for urgent suspicion of cancer; direct pathways for referrals; benchmarking against other Boards in Scotland; public health awareness campaigns for cancer; workforce sustainability and working with regional colleagues; review of the End of Life Care Strategy as part of the clinical strategy engagement; as strategies are reviewed and endorsed there at no financial commitments included in them; and aspirational outcomes.

The **BOARD** approved the Cancer Strategy 2026 – 2033.

The **BOARD** endorsed the strategic direction to ensure alignment with governance, operational planning, and performance oversight.

The **BOARD** confirmed it had received significant assurance for systems and processes and moderate assurance for outcomes.

7. Resources & Performance Committee minutes: 06.11.25

No items were escalated to the Board.

The **BOARD** noted the minutes.

8. Audit & Risk Committee minutes: 22.09.25

No items were escalated to the Board.

The **BOARD** noted the minutes.

9. Finance Report

9.1 A Bone presented the finance report to the end of the Quarter 3 period. The forecast outturn was £10m. He highlighted that the organisation was heavily reliant on non recurring measures and a target of £9m of recurring savings against a larger target set over a 3 year period. In terms of progress he was projecting an outturn of a £3m short fall as £4.47m of savings had been achieved to date. As the financial planning process was worked through the cost pressures would have a recurring impact beyond the financial plan and he suggested a worsening position as the board into the next financial year.

9.2 He further commented that the health delegated functions within the IJB had significantly overspent and were part of the £10m overspend overall. The resource from the Scottish Government would allow the Board to support the IJB in terms of its position in year. The IJB held reserves and it was suggested drawing down on those reserves to offset the IJB deficit position. As had been previously agreed in the framework with the IJB, the IJB should look at its own resources before seeking additional support from partners.

9.3 Discussion focused on: identifying sufficient recurring savings; benchmarking data to identify areas where the system is inefficient in general; performance challenges; directing resources to activities; service redesign; making services cheaper on a cost base and reductionist strategy; preventative services at a secondary prevention level; focus change capacity with QI capacity; activity based costing model; quality dashboard and achieving savings and supporting leadership to deliver cost management functions; mental health and learning disabilities tended to discharge patients to themselves so the system was completely connected; and how does the rest of the system connect together so that primary care and acute become one connection.

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

YTD Performance	£7.85m overspend
Outturn Forecast at current run rate	£10.47m overspend
Projected Variance against Financial Plan (current run rate)	£2.33m improvement
Actual Savings Delivery (current year effect)	£7.53m (actioned)
Projected gap to Forecast	Best Case £10.00m (Forecast Q2) Worst Case £10.47m (trend)

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 as it remained a risk to the financial position but was expected to move substantially over the next few months and the transformational models were also becoming more apparent.

10. Clinical Governance Committee minutes: 12.11.25

No items were escalated to the Board.

The **BOARD** noted the minutes.

11. Quality & Clinical Governance Report

11.1 L Jones provided an overview of the content of the report and highlighted several key elements which included: primary and community services increased demand and pressures for children's services, health visiting, speech and language therapies and children and adolescent mental health services; significant transformational work in acute services; social care teams remained fragile; work space of medicine and the lack of a digital system; and suicide and drug related deaths.

11.2 J Smyth commented that the digital enabling strategy featured heavily as part of a number of areas for digital in the future and was being considered as part of a prioritisation process.

11.3 S Horan commented in regard to the coming home project she was keen for learning to be commissioned by the IJB. The vast majority of care and services in the community were delivered by district nurses and health visitors and the resource did not meet the increasing level of demand. She also commented that in regard to HEPMA, the cost of a drug error was not just a personal cost but also a severe cost and significant risk to the Board especially in regard to the investigation and training requirements.

11.4 L McCallum commented that the lack of a digitised system for prescribing and medicines was a significant safety issue for the Board. She emphasised that it was a serious risk and made the Borders vulnerable and enquired if it might be possible to piggy back on the back of other Boards who had the HEPMA system to reduce the cost of implementation.

11.5 J Smyth agreed to explore linking to other Boards and confirmed that the digital strategy was an enabler and not the driver for HEPMA or other projects.

11.6 D Parker commented that in regard to the coming home project he would be content to commission the new Chief Officer to bring a paper to the IJB once appointed. He also commented that those placements outwith the region required specific staffing models and the fundamental challenge was to bring as many back to the Borders as possible. At the Council meeting the previous week the Council had commissioned a new specialist unit at Tweedbank to repatriate people back to the region. He also commented that from the feedback he had received the Hospital to Home service was well received by those who had experienced it.

11.7 L O'Leary suggested it would be helpful to explore the coming home project and what the mental health and learning disabilities service had to offer as part of system transformation and building the mindset for commissioning.

The **BOARD** noted the report.

The **BOARD** confirmed it had received moderate assurance from the report based on the mixed assurance levels agreed by the Board Clinical Governance Committee.

12. Infection Prevention & Control Report

12.1 S Whiting provided an overview of the content of the report and specifically highlighted: surgical site infection surveillance; hand hygiene compliance; infection control internal audit report completed in 2024; and zero outbreaks across the Borders.

12.2 O Bennett commended the infection control team in maintaining a safe care environment within the context of flu and different challenges across the organisations' footprint to be able to keep beds open and manage flow through the system.

12.3 S Horan acknowledged that hand hygiene compliance rates often dipped during times of pressure in the system, when protected training time for staff was removed. She emphasised that hand hygiene compliance was part of the mandatory learning programme for clinical staff.

The **BOARD** noted the report.

The **BOARD** confirmed it had received moderate assurance from the report.

13. Whistleblowing Quarter 3 Report

13.1 I Bishop provided an overview of the content of the report .

13.2 L Livesey requested that the average time for a full response be included in the report at Indicator 4.

13.3 L Livesey commented that from national data the average whistleblowing case was 111 days and NHS Borders was significantly beyond that average. The number of cases varied significantly and some took longer to resolve than others and that spoke to the need to have a real speak up culture and people strategy to encourage that confidence to speak up. She highlighted that since being in post there had not been an executive lead for whistleblowing for a considerable period of time and she was looking forward to the appointment of a new Director of HR to progress the work on a wider speak up culture to provide the Board with greater confidence.

13.4 L Jones observed that the aim to respond within 20 working days was an ambitious target, especially if the Board wished to uphold high standards. Achieving that timeline was particularly demanding when considering the services required to address complaints and adverse events. Furthermore, the process could be prolonged by external reviews, which could take months before an external reviewer was identified and commissioned. That delay was indicative of the challenges faced in shifting performance on that indicator. She further emphasised that timely responses and the management of whistleblowing cases were integral to the Board's safety culture. There was a strong belief that embedding those processes across all activities would help foster psychological safety within the organisation. Whistleblowing was just one indicator, and the Board's ongoing work around adverse events, HR processes and wider systems collectively contributed to a robust safety culture. If those systems functioned effectively, it may not be problematic to see a low number of whistleblowing cases, as discussed at the Whistleblowing Governance Group meeting the previous week. In looking ahead she highlighted the importance of integrating whistleblowing and safety-related training into the core mandatory and statutory training programmes. That approach was seen as part of a broader set of

actions designed to influence and strengthen the overall culture within the organisation.

13.5 L Livesey highlighted the importance of cultivating a robust speak up culture within the organisation. She emphasised that the analysis and uptake of tools such as iMatter and other staff surveys played a crucial role in that endeavour. Notably, those surveys had demonstrated a low outturn, which formed part of a broader piece of work aimed at understanding staff engagement and their willingness to voice concerns. That comprehensive approach was expected to be further informed by forthcoming guidance from the Scottish Government. The guidance would focus on integrating various strands of staff feedback to present a more holistic view of how confident and competent staff felt when it came to speaking up within the organisation. That initiative would contribute to the wider efforts to strengthen organisational culture and ensure that staff felt empowered to raise issues safely and constructively.

13.6 P Moore commented that in managing and supporting staff, it was evident that more needed to be done than had been done historically. The reductions in staff numbers, finance, and corporate services had brought significant challenges for both managers and the wider workforce. To address those difficulties, it was essential that a comprehensive range of options and support were offered to managers to ensure teams were equipped with all the necessary resources. It was crucial that conversations were grounded in organisational values and behaviours, and open dialogue was maintained with the workforce. He further commented that the organisation consistently asked a great deal of staff, who demonstrated exceptional commitment in meeting complex daily demands within the resources available to them. While not everything would be flawless, it was crucial to establish a coherent system and process spectrum, including whistleblowing mechanisms at one end, that collectively supported the social compact. The imminent appointment of a new HR Director presented an excellent opportunity to address that important work.

13.7 Further discussion focused on: training; system wide learning following complex cases; benchmarking to other Boards.

The **BOARD** noted the Whistleblowing Quarter 3 report.

The **BOARD** confirmed it had received moderate assurance from the report.

14. NHS Borders Performance Scorecard

14.1 J Smyth provided an overview of the content of the report and highlighted: rewiring the organisation; format of report evolving; and that there were no new indicators included at that time.

14.2 O Bennett highlighted several salient points which included: the pressure that staff were operating under and the increased acuity of patients on admission and waits over 4 hours in the Emergency Department; acute assessment unit performance; progress in reducing elective waiting times as part of the elective recovery plan; progress in achieving no patient waiting more than 52 weeks by the end of March, however there were 2 specialties at risk of not achieving the target, Dermatology and Orthopaedics; cancer performance was improving in regard to waits over 62 days;

and a similar pattern in diagnostics; and in terms of delayed discharges the figures were the lowest they had been for hospital delayed discharges for the past 2-3 years.

14.3 The Chair recorded her thanks to all those who had worked over the winter and festive period.

14.4 P Moore suggested a paper be brough to the Resources & Performance Committee in May to open up a discussion on the triangulation of non elective flow, the investment put in and expected outcomes, as well as 12 hour breaches.

14.5 Further discussion focused on: the importance of team work with colleagues in social care and social work in achieving sustained reduction in delayed discharges; move towards seasonal planning; shift of resources from secondary care to the community setting; expansion of Home First; Frailty Unit opened and Integrated Discharge Team working well; category 1 delays for neurological waits for children and young people; and flu vaccination performance.

The **BOARD** agreed that a paper be taken to the Resources & Performance Committee in May on the triangulation of non elective flow, the investment put in and expected outcomes, as well as 12 hour breaches.

The **BOARD** noted the report.

The **BOARD** confirmed that it had received moderate assurance for systems and processes and limited assurance for outcomes from the report given the Board acknowledged that it was not achieving targets and delivery standards.

15. Scottish Borders Health & Social Care Integration Joint Board minutes: 24.09.25

No items were escalated to the Board.

The **BOARD** noted the minutes.

16. Board Committee Appointments

16.1 The Chair provided an overview of the content of the report.

The **BOARD** formally appointed L O'Leary as Vice Chair of the Board.

The **BOARD** noted the changes in Non Executive memberships of its Committees as set out in the NHS Borders Non Executives Committee Chart.

The **BOARD** confirmed that it would continue to operate with one Non Executive vacancy for the period 2026/27 which would continue to contribute to the savings target of the Board.

The **BOARD** confirmed that it had received significant assurance from the report.

17. Sub National Planning and Delivery Committee (East) Update

17.1 P Moore provided an update on the sub national planning and delivery committee for the east. He highlighted: the workstreams that had been formed; the promotion of

rural and island populations; the meetings that had been held to date; the interim staff that were in place to support the workstreams and the anticipated formal appointments to those positions; and the involvement of Executives from NHS Borders in several of the workstreams.

17.2 The Chair highlighted that P Moore was the Senior Responsible Officer (SRO) for the business systems programme, J Smyth was involved in the digital front door workstream, L McCallum was involved in the health care services workstream and S Horan and A Bone were members of the island and rural workstream.

The **BOARD** noted the report.

18. Any Other Business

The **BOARD** noted there was no further business identified.

19. Date and Time of next meeting

19.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 2 April 2026 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams.

Borders NHS Board Action Point Tracker

Meeting held on 26 June 2025

Agenda Item: Health & Care (Staffing) (Scotland) Act 2019 - Annual Report

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2025-4	21	The **BOARD** noted the report and demitted it to the Staff Governance Committee to review and represent to the Board with assurance that it was evidencing compliance with the Act.	~~**A Carter**~~ **S Horan**	**April 2026**	**In Progress:** The report had been scheduled for the Staff Governance Committee meeting to be held on 16 October 2025. **Update 02.10.25:** The report would be presented to the Staff Governance Committee at its next meeting on 6 November 2025. **Update 04.12.25:** The report would be presented to the Staff Governance Committee at its next meeting on 29 January 2026. **Update 05.02.26:** S Horan confirmed that the report had been submitted to the Staff Governance Committee and would be brought to the Board on 2 April 2026 to complete the action on the action tracker. **Complete:** Report is a substantive item on the 2 April board meeting agenda.	G

Agenda Item: Code of Corporate Governance sectional refresh

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2025-5	24	The **BOARD** agreed that the Area Partnership Forum Terms of Reference be reviewed and resubmitted.	**I Bishop** **J McLaren**	**June 2026**	**In Progress:** John McLaren to represent the APF ToR to the next APF meeting for review and onward submission to the Board for formal approval. **Update 02.10.25:** J McLaren to confirm the updated APF ToR would be available for formal board sign off as part of the next Code of Corporate Governance Sectional Refresh. **Update 04.12.25:** J McLaren confirmed the updated APF ToR would be available for formal board sign off as part of the next Code of Corporate Governance Sectional Refresh. **Update 05.02.26:** I Bishop confirmed that the revised APF ToR were part of the Sectional Refresh of the Code of Corporate Governance to be presented to the Audit and Risk Committee in March and then to the Board on 2 April for formal approval. **Complete:** Report is a substantive item on the 2 April board meeting agenda.	G

Meeting held on 4 December 2025

Agenda Item: Health Inequality Progress Report

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2025-6	8	The **BOARD** agreed to add an overview of what was currently done in regard to Health Inequalities and Social Prescribing to the Action Tracker.	**S Bhatti**	**On going**	**Update 05.02.26:** S Bhatti confirmed that progress had been made. A locum consultant had been appointed to lead the joint strategic needs assessment and undertake the option appraisal. Recruitment was also progressing to an epidemiology intelligence function and progress was being made liaising with Live Borders on the waiting well initiative and social prescribing service.	

Agenda Item: Finance Report

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2025-7	11	The **BOARD** agreed to include progress in regard to "cost avoidance" for the following financial year on the action tracker.	**A Bone**	**June 2026**	**In Progress:** This will be implemented within the Finance Report from Month 1. **Update 05.02.26:** A Bone confirmed that cost avoidance reporting would be included in the next financial year and the Quarter 1 Report.	

Meeting held on 5 February 2026

Agenda Item: Chief Executive's Report

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2026-1	5	The **BOARD** agreed to receive a paper on Nursing Workforce and future delivery of services at the June Board meeting.	**S Horan** **A Keen**	**June 2026**		A

Agenda Item: NHS Borders Performance Scorecard

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2026-2	14	The **BOARD** agreed that a paper be taken to the Resources & Performance Committee in May on the triangulation of non elective flow, the investment put in and expected outcomes, as well as 12 hour breaches.	**O Bennett** **G Clinkscale** **A Bone**	**May 2026**	**Complete:** Item added to May R&PC meeting agenda.	G

Meeting held on ……..

Agenda Item:

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2026-3						

KEY:	
Grayscale = complete:	
	Overdue / timescale TBA
	Over 2 weeks to timescale
	Within 2 weeks to timescale

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Chief Executive's Report**
Responsible Executive/Non-Executive:	**Peter Moore, Chief Executive**
Report Author:	**Lesley Shillinglaw, EA to Chief Executive**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Delivery Plan
- Emerging issue
- Government policy/directive
- Legal requirement
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

In this update I will provide an update on the key areas of activity over the past period, including a summary of the Board Chief Executives national update, an overview of the Ministerial visit held on 11 March 2026, and a progress update on the Clinical Strategy. Together, these highlight the continuing focus on national performance requirements, positive external engagement, and ongoing delivery of our strategic priorities across urgent care, community-based services, and system transformation.

2.2 Background

Board Chief Executives (BCE) – The BCEs met in February and March 2026.

Ministerial Visit – Minister for Social Care and Mental Wellbeing, Mr Tom Arthur MSP visited NHS Borders on 11th March 2026.

Clinical Strategy – Implementation Progress.

Embassy of Denmark Reception held on 11 March 2026.

Health & Social Care Transformation 2026 Conference held on 12 March 2026.

2.3 Assessment

Since the last report to the Board, 6 new consultants have been interviewed, offered and accepted a consultant post.

2.3.1

New Consultant	Post	Start Date
Dr Alex Holme	Consultant Dermatologist	April 2026
Dr Maria Khan	Consultant Radiologist	April 2026
Dr Louisa Betram	Consultant Paediatrician	April 2026
Dr Christopher Tee	Consultant Paediatrician	April 2026
Dr Jennifer Brennock	Consultant in Palliative Medicine	April 2026
Dr Catriona Dunlop	Consultant Psychiatrist - MHOAS	June 2026

Quality/ Patient Care

The Senior Medical Staffs Committee receives a quarterly report on forthcoming medical vacancies, new long term Consultant appointments (including locums) and consultant posts filled by long term locums.

2.3.2 Workforce

Successful recruitment to substantive consultant posts supports the sustainability of services.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed in the preparation of this paper. However Equality and Diversity obligations are fully complied with in the recruitment and selection process.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

Not applicable.

BCE Update

February BCE meeting update: At the February BCE meeting, discussions focused on finance, workforce and digital, reflecting national pressures and the ongoing need for coordinated action across Boards to support sustainable service delivery.

March BCE meeting Update: At the March BCE meeting, key items included a deep dive on racialised health equalities, which highlighted the importance of addressing inequity across pathways and outcomes, and an update on NSD service pressures, particularly the financial impact of out-of-area costs. These discussions continue to shape national priorities and support alignment across NHS Scotland Boards.

Ministerial Visit – 11 March 2026

Tom Arthur MSP, Minister for Social Care and Mental Wellbeing, visited NHS Borders on 11 March 2026 to see progress across Hospital at Home, Frailty, Integrated Discharge and community-based models of care. The visit highlighted improved patient flow, strong integration with social care, reduced avoidable admissions, and the development of the Hawick Walk-In Service.

Clinical Strategy – Update

NHS Borders continued to progress clinical strategy priorities including Hospital at Home expansion, strengthened Frailty pathways, and maturation of the Integrated Discharge Team and Home First model. These programmes continue to improve patient flow, reduce length of stay and enhance community-based care. Clinical strategy next step sessions are scheduled for whole system MDT engagement sessions across clinical services and enabler leads and teams on 31 March and 1 April to finalise priorities for the next phase of strategic delivery.

Embassy of Denmark Reception

The reception brought together key Danish and Scottish stakeholders from government and industry within the digital and healthcare sectors, with the aim of strengthening dialogue and cooperation between Denmark and Scotland. It was an opportunity for Scotland and Denmark to interact closely and knowledge share to strengthen the healthcare sector across the nations. The Danish delegation featured five innovative

Danish companies interested in exploring Scotland and the opportunities in the healthcare sector.

Health & Social Care Transformation 2026 Conference
The service outlined at the conference will be a single means of access to citizen health and care information and to health and care services as part of a phased introduction nationwide. The critical development is part of a suite of national policies designed to bring Scotland's health and social care systems into a new era, with digital technology seen as a crucial part of NHS reform, modernisation and future service delivery.

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 is not required

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

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

2.3.9 Route to the Meeting

This report has been prepared directly for the Board.

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:

- **Moderate Assurance (recommended)**

3 List of appendices

Not applicable.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**NHS Borders Deliverables Update**
Responsible Executive/Non-Executive:	**J Smyth, Director of Planning and Performance**
Report Author:	**K George, Planning and Performance Officer**

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

NHS Borders committed to a number of deliverables as part of the Organisational Strategy that was approved at the Board in April 2025. This paper provides an overview on the status of each of these deliverables and, for those still in progress, sets out the approach that will support their successful completion during 2026/27.

The Board is being asked to note this update and progress that has been achieved across the organisation.

2.2 Background

The Board approved NHS Borders Organisational Strategy for 2025 – 2030 in April 2025, following a large-scale staff and public engagement exercise. The engagement provided NHS Borders the following opportunities:

- To reconnect with our staff and public
- To understand what was important to them
- To link this back to our staff's purpose
- To provide a clear vision of where we were going, and how this linked to our NHS Borders values
- To provide the blueprint for our bridge towards this 2030 vision

As part of the Organisational Strategy, NHS Borders committed to ten deliverables for Year 1, selected because they create the essential foundations needed to stabilise the organisation, strengthen core infrastructure and enable successful delivery of the 2025 – 2030 Organisational Strategy.

These deliverables focus on addressing the biggest operational and clinical risks, supporting financial sustainability, improving performance and ensuring staff and partners are aligned around a shared purpose. These were chosen to ensure early progress in areas that unlock system-wide change, provide clarity for teams, and set the conditions for the more ambitious redesign and transformation planned within the five years.

The ten Year 1 Deliverables are:

1. Develop and agree a Clinical Strategy
2. Develop and agree a set of Enabling Strategies
3. Implement a revised internal operating model (rewiring the organisation)
4. Further engagement with staff regarding Organisational Values and Behaviours
5. Develop a set of local performance trajectories that are more ambitious than those set out within the Annual Delivery Plan
6. Achieve a 3% financial efficiency saving
7. Deliver our Social Compact
8. Ensure 100% of available staff receive an annual appraisal
9. Consistently celebrate staff and team learning and achievements
10. Continue our two-way dialogue with staff, communities and partners

2.3 Assessment

A significant effort has been made across the organisation to implement the Year 1 deliverables and as of April 2026, we have implemented five of the ten, with the outstanding five being progressed through multiple workstreams during 2026/27.

An overview of each deliverable is outlined below for information.

Clinical Strategy

The Clinical Strategy for NHS Borders was approved by the Board in December 2025. The strategy focussed on a life stage approach which aligned with the national population health planning framework to look at this through a lens of person-centred care. The Clinical Strategy ambitions are:

- To provide care closer to home by providing resources and services to community-based care
- To deliver person-centred care by focussing on what matters to each individual

- Use Technology Enabled Care to provide seamless care, efficient pathways and better access to services
- Ensure NHS Borders has an Empowered Workforce which are supported to deliver high-quality, integrated care
- Prioritise Prevention and Early Intervention
- Ensure fair and timely access to care for all, including speciality and tertiary services
- Work in partnership with health, local authorities and third sector organisations
- Use resources widely to ensure safe, effective and sustainable care for the future

We are now at the stage of developing the organisations Year 1 Delivery Plan using the 2030 ambition of the organisation. This is a whole system approach with workshops scheduled at the end of March and end of April to bring clinical and support colleagues together from across the Borders health system to cross check the delivery plans and ensure that staff have had the appropriate opportunity to comment on or influence the Year 1 commitments.

Enabling Strategies

Our Clinical Strategy sets out how we will transform care across life stages, improve outcomes and deliver services closer to home. Achieving this vision requires more than clinical redesign. We are reliant on our nine Enabling Strategies to support this change happening. These are: Partnerships, Quality, Risk Management, Research and Innovation, Digital, People, Finance and Property. The nine Enabling Strategies were presented in draft to the Board in December 2025, and final versions will be presented at the Board in June 2026 for final approval.

The Enabling Strategies have been aligned to one of our existing four Quality Management System Pillars, and workshops are in progress to develop a clear delivery plan for each pillar which is outlined below. Alongside internal programme management, this will ensure that there is a clear governance route for progressing the objectives of the Enabling Strategies.

Pillar	Enabling Strategy
Public	Partnerships
Leadership	Quality Risk Research and Innovation
Business	Digital Finance Property & Sustainability
Staff	People

Internal Operating Model

Over the last year there have been changes made to our internal governance and decision-making frameworks, that were presented to and supported by Resource & Performance Committee in April 2025. The overall aim of the rewiring of the organisation was to:

- **Streamline Governance**: Simplify decision-making structures to provide clear direction and empower teams
- **Enhance Clinical Leadership**: Encourage team agency and transparent planning, capturing innovation at the ground level
- **Broader Engagement**: Increase clinical involvement in decision-making to reset the organisational culture
- **Balance Priorities**: Create a space for open discussion of competing priorities among clinicians and managers to find balanced solutions

These changes were split into 3 phases:

- **Phase 1** initially focussed on our highest-level internal decision making at a whole system level. Borders Delivery Group was introduced as the new internal leadership decision body which provides clear routes for escalation and encourages clinical and operational agency within the organisation. This group replaced the Business Meeting of the Borders Executive Team and also Quality & Sustainability Board.
- **Phase 2** included a review of the 3 clinical business units governance and decision-making processes to ensure they operate within a standard framework to report into Borders Delivery Group. First was the development of the Hospital Management Board in Acute. This is being mirrored in a Primary & Community Services, Mental Health and Learning Disability Management Board which is currently underway.
- **Phase 3** includes a refresh of the Board Committees, assurance and Governance routes which is currently underway and will extend into 2026/27.

During 2026/27, we aim to introduce System Improvement and Transformation Groups within each of the Business Units across the organisation that will report into the Borders Delivery Group.

Values & Behaviours

As set out in the Organisational Strategy, the Values & Behaviours programme focused on engaging with staff to define the behaviours that align with our values, as well as those that do not and will not be accepted. This engagement informed the development of a clear behavioural framework, which was approved by the Board in December and embedded within the strategy.

We are now moving into the next phase of this work, focused on embedding the framework across the organisation. BET is currently considering how this is taken forward, including a drafted communications approach (which has been submitted for review) to support staff to consistently see and experience our values in practice. Consideration is also being given to absorbing this work within the wider People Strategy, alongside HR and OD activity to reinforce expectations and ensure accountability where behaviours do not align.

Local Performance Trajectories

Over the past year we have strengthened our local performance trajectories by moving to a clearer, more consistent and data-driven approach through the introduction of the Integrated Performance Report (IPR). The first iteration has already improved visibility of performance across the organisation and supported more timely review and

discussion at both Resource & Performance Committee and Board Meetings. Alongside this, we also set our own internal ambitious but realistic performance trajectories for 2025/26 across Planned Care, Unscheduled Care, Cancer, Diagnostics and Mental Health to support recovery and improve access. There have been significant improvements across many of these key areas throughout the last 12 months.

In 2026/27 we will continue to build on this progress by expanding the measures included and refine trajectories to provide stronger assurance, clearer accountability and earlier identification of risks as we deliver the Organisational Strategy.

3% Financial Efficiency Savings

This financial year, all business units were set a savings target of **3%**, equating to **£9.1m** in total. Each area was asked to identify 3% of its budget that could be released as savings. Significant effort went into planning, monitoring, and ensuring accountability for delivery. A number of grip-and-control measures supported this work, including additional scrutiny of non-patient-care spend and restrictions on booking external venues.

Across the organisation, several areas are expected to meet their full savings requirement:

- **Acute Services** expect to achieve their 3% target, with around half of this delivered through medicines and prescribing efficiencies.
- **P&CS (CMT 1 & 2)** are expected to reach their target, mainly through service redesign and contract changes.
- **Primary Care Medicines & Prescribing** are anticipated to achieve their 3% target through formulary switches and related prescribing savings.
- **MH&LD** are expected to deliver their 3% target through a creative income-generation approach using inpatient beds.
- **Psychology** are expected to achieve their 3% savings target.
- **Estates** made their 3% target supported by a Scottish Government energy grant.
- **Clinical Governance & Risk**, and **Planning & Performance** all are expected to achieve their required savings.

Some services were unable to fully meet their target due to operational pressures. For these areas, the unmet portion of the savings requirement will roll forward into the next financial year.

In total, **£7.3m** of projected savings were achieved during the year. Next financial year, the organisation needs to deliver savings of **£13m**, with business units being asked to achieve a higher savings target.

Social Compact

A draft Social Compact has been developed and is currently being reviewed within the organisation. The Social Compact will also be reviewed by the Area Partnership Forum ahead of being formally signed off.

The Social Compact focuses on four key areas:

- Owning Our Need to Improve
- Creating Space for Improvement
- Developing our Improvement Capability

- Maximising NHS Borders Employee Benefits

The Social Compact sets out the shared commitments between NHS Borders and our workforce, creating the conditions for kind, safe and a continuously improving organisation. It aims to strengthen psychological safety, embed our values and behaviours, ensures that staff have protected time for improvement and also maximise access to meaningful wellbeing support and employment benefits.

In 2026/27, this will be progressed through the Wellbeing Group Action Plan which will focus on making staff benefits clearer and more accessible, enhancing wellbeing resources and ensuring improvement activities are supported through dedicated time and consistent methods.

Annual Personal Development Appraisals

Appraisals play a vital role in supporting healthcare staff by providing protected time for meaningful, two-way conversations about performance, wellbeing, development and career aspirations. In a complex and pressured healthcare environment, effective appraisal helps ensure staff feel valued, supported and clear about expectations, while also identifying learning needs and opportunities that directly contribute to safer, higher-quality patient care. Our commitment to ensuring all staff receive regular appraisals reflects our wider staff governance responsibilities and our belief that a skilled, engaged and supported workforce is fundamental to delivering sustainable services. By prioritising appraisals, we strengthen individual accountability, support personal development planning, and create the conditions for continuous improvement across NHS Borders, ensuring staff remain central to shaping the future of our organisation.

Recognising that this is an ongoing deliverable, this will remain an annual commitment moving forward and has been identified as a key deliverable within the Staff Engagement Quality Management Pillar. The current draft Nursing, Midwifery and AHP enabling strategy supports this message and the commitment NHS Borders has made to enabling and facilitating staff appraisals.

Celebrating Success

Work has progressed to understand existing approaches to recognising and celebrating staff and team learning and achievement, and to develop a proportionate, organisation-wide approach. This has included an audit of current celebration and recognition mechanisms across the organisation, alongside staff engagement activity to understand how colleagues would like success to be recognised and learning shared. Insights from this engagement directly informed the development of a Celebrating Success toolkit, which has now been completed and is being reviewed.

Subject to approval, the Celebrating Success toolkit and submission form will be launched in the next couple of months, providing a consistent mechanism for staff to highlight achievements and learning. Learning and achievements will then be recognised and shared through the agreed channels. Progress and uptake will be monitored, and a review will be undertaken later in the year to assess how the approach is working in practice and identify any opportunities for refinement or improvement.

Two-way conversations

Significant progress has been made during 2025/26 on the stated deliverable of "continued two-way conversations with our staff, communities and partners". Having undertaken a significant and highly successful public engagement exercise between January and April 2025, to inform the development of the Organisational and Clinical Strategies, the primary focus for 2025/26 has been on internal conversations to inform the developing clinical strategy. This included a full week of face-to-face engagement sessions hosted at Borders College from 7-11 July 2025, followed by additional sessions at the BGH week commencing 14 July. These sessions were followed up by workshops at speciality level to continue the conversations based on feedback received, with a specific output of designing speciality plans to be included in the Clinical Strategy which was published in December 2025.

Alongside these internal conversations, a dialogue has started between staff, public and partners to inform the development of the Partnerships Strategy, which will be published with the suite of enabling strategies in June 2026.

Engagement with the public is vital and we intend to hold further conversations with local communities in the summer, to talk openly about the Clinical Strategy, what it means in practice, and the shared vision for delivering it over the coming years. These conversations will help ensure that local voices continue to shape how services develop and that NHS Borders remains accountable for progress against our priorities.

2.3.1 Quality/ Patient Care

The implementation of our Year 1 Deliverables will contribute to a more supportive and collaborative environment and will enhance the quality, safety and consistency of patient care. This approach aims to improve health outcomes, increase patient satisfaction, and ensure services are responsive to the needs of our patients.

2.3.2 Workforce

The implementation of our Year 1 Deliverables has provided our workforce with a clear direction and ensured that staff remain central to shaping the future direction of NHS Borders, helping us build a dedicated, skilled, and sustainable workforce capable of delivering high-quality care now and into the future.

2.3.3 Financial

A financial strategy continues to be developed and refined which will set out the resources available to NHS Borders to continue the progress of the Year 1 deliverables outlined within the Organisational Strategy, alongside the implementation of the Clinical Strategy and the other Enabling Strategies.

2.3.4 Risk Assessment/Management

A full risk assessment will need to be considered for the continued delivery of the commitments outlined within this paper.

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. As outlined above we are planning to continue further engagement with both staff and public throughout the course of 2026/27 as we progress with the commitments highlighted within this paper.

2.3.6 Climate Change

Although clear impacts on climate change have not been highlighted, we continue to support initiatives that have a positive impact on Climate Change and this can be found in more detail within our Environment and Sustainability Strategy.

2.3.7 Other impacts

These will be assessed as we continue to progress with the commitments above.

2.3.8 Communication, involvement, engagement and consultation

There has been continuous communication, engagement and involvement from many stakeholders across the organisation regarding the commitments outlined within this paper, including:

- BET
- Borders Delivery Group
- Staff Engagement QMS Pillar
- Business Process QMS Pillar
- Area Partnership Forum

2.3.9 Route to the Meeting

The development and delivery of the commitments outlined within this paper, alongside the approaches being taken have been discussed across a range of groups and committees.

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. It is suggested the members consider the following assurance levels following discussion of the paper:

- Moderate assurance for systems and processes
- Limited assurance for outcomes

3 List of appendices

None

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**NHS Borders Anti-Racism Plan**
Responsible Executive/Non-Executive:	**Avril Keen, Director of People and Culture**
Report Author:	**Cathy Wilson, Primary & Community Services General Manager**

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):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Scottish Government has issued national guidance requiring all NHS Boards to develop and publish an Anti-Racism Plan, with an expectation that NHS Borders publishes its plan by 31st March 2026.

An NHS Borders Anti-Racism Plan has been developed in line with this guidance and has been substantially strengthened through engagement and co-production with the NHS Borders Minority Ethnic Staff Network. A review against national guidance confirms the plan is compliant and is therefore ready for publication on our website.

2.2 Background

In line with Scottish Government guidance that Anti-Racism Plans should be developed through engagement and co-production, NHS Borders' first draft Anti-Racism Plan was prepared in June 2025 by the then Director of Human Resources, intended as an initial basis for wider sharing and discussion.

In August 2025, the draft was shared with volunteered members of a proposed Anti-Racism Committee. While this draft provided a helpful starting point, it did not fully address several elements of the national guidance, including explicit accountability arrangements, delivery timescales, resourcing, use of data, assurance mechanisms, and approaches to identifying and addressing racism-related concerns.

In September 2025, the draft was therefore circulated more widely to the NHS Borders Minority Ethnic Staff Network to support deeper engagement and to incorporate lived experience. The plan has since been developed and progressed through collaborative working with the Minority Ethnic Staff Network and supporting colleagues across NHS Borders.

As a result of extensive engagement and co-production, significant additions and refinements have been made. The final version is substantially more comprehensive, more closely aligned with national guidance, and is now presented for final publication.

2.3 Assessment

When assessed against Scottish Government and NHS Scotland Anti-Racism Plan guidance, the current draft demonstrates strong alignment across the six national core domains:

1. **Leadership & Accountability**
   Clear intent for Executive leadership, an Anti-Racism Committee, and reporting through governance structures to the Board with progress tracked via KPIs.

   The Chief Executive has implemented a programme of reverse mentoring around each protected characteristic. Each Executive has been assigned a protected characteristic to take forward. The Director of People and Culture is responsible for Race.

   The plan is additionally supported by the Director of Public Health, with senior leadership provided by the General Manager for Primary & Community Services.

2. **Data & Evidence**
   Strong focus on improving ethnicity data for staff and patients, use of dashboards, KPIs and equality impact assessments. This will form a key part of the implementation of the plan.

3. **Workforce**
   Fair recruitment and progression, targeted development, reverse mentoring,

culturally competent training, and monitoring HR processes by ethnicity.

4. **Equity-Focused Service Delivery**
   Action on known racialised health inequalities (e.g. diabetes, cardiovascular disease, perinatal care, mental health), including co-design, interpreting support and children's rights.

5. **Engagement & Co-Production**
   Active involvement of minority ethnic staff and communities through the Minority Ethnic Staff Network and wider engagement mechanisms.

6. **Embedding Anti-Racism Across the Organisation**
   Explicit recognition of institutional and structural racism, with anti-racism being mainstreamed across clinical, people, digital, estates and financial strategies.

2.3.1 Quality/ Patient Care

Positive impact is anticipated through targeted action on racialised health inequalities, improved use of ethnicity data, and more equitable service design and delivery. No negative impact on patient care is identified.

2.3.2 Workforce

The plan has a significant positive impact on staff governance, aiming to improve staff experience, fairness in recruitment and progression, psychological safety, and confidence in raising racism-related concerns. Some operational capacity will be required to support delivery, monitoring and reporting.

2.3.3 Financial

Scottish Government guidance expects Anti-Racism Plans to be resourced. Where no new funding is identified, there is a requirement for clarity on how capacity will be created or prioritised within existing resources.

2.3.4 Risk Assessment/Management

There is a significant organisational and reputational risk if NHS Borders does not publish a compliant Anti-Racism Plan by March 2026. Failure to progress delivery may also undermine staff confidence and national assurance. Mitigations include formal governance oversight, clear accountability, agreed resourcing, and regular reporting.

The Anti-Racism plan supports the compliance of Equality Impact Assessments (EQIAs). Failing to complete EQIAs as part of the Public Sector Equality Duty could pose severe financial, legal, and reputational risks.

2.3.5 Equality and Diversity, including Health Inequalities

This plan directly supports the Public Sector Equality Duty, the Fairer Scotland Duty, and NHS Borders' Equality Outcomes. It explicitly addresses institutional racism, workforce inequality, and racialised health inequalities.

2.3.6 Climate Change

No direct impact on climate change or carbon footprint is identified.

2.3.7 Other Impacts

There are interdependencies across all Business Units, including Corporate Services, IM&T, Estates, Workforce, Planning & Performance, Quality Improvement, Communications and Public Health. Active participation and accountability are required for the plan to be meaningful and deliverable.

2.3.8 Communication, Involvement, Engagement and Consultation

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

Engagement and co-production has taken place, including:

- NHS Borders Minority Ethnic Staff Network
  - September 2025
  - December 2025
  - January 2026
- Borders Executive Team
  - January 2026
- NHS Borders Delivery Group
  - January 2026
- Staff Governance Committee
  - January 2026
- Planning & Performance, Occupational Health, Health and Safety, Patient Experience Team
  - February 2026
- Borders Executive Team
  - March 2026

Feedback from engagement has directly shaped and strengthened the draft plan.

2.3.9 Route to the Meeting

- Virtual Circulation to ARC Volunteer Group
  - June 2025
- Minority Ethnic Staff Network (Virtual and face to face)
  - September 2025
  - November 2025
  - December 2025
  - January 2026
- NHS Borders Delivery Group, 28 January 2026
- Staff Governance Committee, 30 January 2026

2.4 Recommendation

The Board is asked to:

Decision:

- Approve the Anti-Racism Plan in principle, noting its substantial alignment with national guidance; and
- Support commitment of resources to progress action plan.

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

- **Moderate Assurance**
  The Anti-Racism Plan is substantially aligned with national guidance and underpinned by strong engagement, enabling it to be published. However, some key elements required for full assurance remain in development, as the Plan itself sets out further actions for the organisation.

  Our ambition is to improve the health and wellbeing of minority ethnic communities across the Borders by ensuring services are accessible, culturally responsive and informed by robust evidence and decision-making.

  Systems and processes are largely in place from a Staff Governance perspective, but some areas require further development to provide full assurance. Workforce-focused actions such as fair recruitment and progression, targeted training and development, established engagement mechanisms, explicit recognition of institutional racism, and the planned use of KPIs and workforce data are in progress.

  Further work is needed to improve the identification, recording and shared learning from racism-related concerns and complaints from both the public and staff.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Anti-Racism Plan FINAL

NHS Borders Anti-Racism Plan 2025-2027

NHS BORDERS

Fairness, Equity and Inclusion

“ We’re practically there - this is about being comfortable that it reflects what we believe and what we’re prepared to act on. ”

- Ethnic Minority Forum

Our Vision and Guiding Principles

VISION

To be recognised as Scotland's leading healthcare organisation for fairness, equity, and inclusion - where every person feels respected, valued, and safe.

This Anti-Racism Plan sets out the first steps in a continuous journey toward eliminating racism within NHS Borders. It provides a clear framework and roadmap for embedding anti-racism across our organisation, aligning with our Clinical Strategy and wider organisational plans. Through this approach, we identify immediate priorities, define measurable outcomes, and establish enduring principles that will guide us toward creating a healthcare system where fairness, equity, and inclusion are at the heart of everything we do.

NHS Borders recognises that racism is not limited to individual acts but can be embedded within organisational systems, policies and practices. Addressing institutional and structural racism requires sustained, systemic change, not solely cultural or behavioural interventions.

NHS Borders will champion cultural diversity, challenge discrimination, and embed anti-racism into everything we do. We commit to creating an environment where every staff member, student, volunteer, patient - including every child - feels respected, valued, and safe. Our approach will actively promote fairness, equity, and inclusion across all services and decision-making processes, guided by enduring principles that keep us on the right path.

Our Guiding Principles

The delivery of this Anti-Racism Plan is underpinned by four guiding principles that shape how we design, implement and assure our actions. These principles ensure that our commitment to anti-racism is consistent, measurable and embedded across NHS Borders.

Accountable Leadership and Governance

Ensuring clear governance, ownership and reporting at all levels so that anti-racism commitments are actively monitored, challenged and delivered, rather than remaining aspirational.

Empowered Staff and Communities

Creating safe, structured and meaningful opportunities for minority ethnic staff, service users and communities to influence decisions, contribute to policy development and co-design services.

Evidence-Based

Using robust data, insight and measurable outcomes to understand disparities, track progress and drive continuous improvement in anti-racism activity.

Inclusive Culture

Embedding cultural awareness, equity and fairness across organisational culture, leadership and service delivery so that all individuals, including children and those from racialised minorities, feel respected, represented and able to participate fully.

Road to **EMPOWERMENT**

Engagement and Empowerment

A clear road map is essential to guide the implementation of the Anti-Racism Plan. It provides a structured timeline and sequence of actions, ensuring that objectives are achieved in a logical and measurable way. The road map should outline short-term, medium-term, and long-term priorities, identify responsible teams, and include milestones for monitoring progress. This approach helps maintain accountability, transparency, and momentum across all areas of engagement and empowerment.

NHS Borders operates an Ethnic Minority Forum (EMF) for staff, currently chaired by a local health professional/trade unionist and member of the NHS Scotland Ethnic Minority Forum. The EMF is a safe space where workers can discuss any challenges they may be facing and is a structured opportunity for workers from racialised minorities to engage in self/mutual help way around a variety of workplace and broader (outside the workplace) issues. Colleagues from throughout NHS Borders are invited to the forum to talk to issues or just be available to answer questions. The EMF is developing a Terms of Reference and exploring how it might hold line managers to account for improvements in anti-racism practice and culture, operating with the full support of the Board. The organisation will also actively celebrate the work and successes of the EMF and make its impact visible to the wider organisation, helping to build understanding, confidence and engagement.

The Chief Executive has implemented a programme of reverse mentoring around each protected characteristic. Each Executive has been assigned a protected characteristic to take forward. The Director of People and Culture is responsible for Race.

NHS Borders also operates an Equality, Diversity & Inclusion in Employment Group, co-chaired by the Employee Director and Director of People and Culture. The groups works to an annual workplan and tackles intersectional issues involving the various protected characteristics (age, disability, gender reassignment, maternity/pregnancy, religious/spiritual belief, sex, sexual orientation). The group intends to celebrate its successes (commissioning of training interventions, roll-out of Pride Pledge & Badge, support for International Recruitment) and make its impact visible to the wider organisation.

During Winter 2024/25, NHS Borders launched a large-scale engagement exercise to hear from our staff and communities about what NHS Borders means to them, what they value about our services and where there are opportunities for improvement. The information gathered was to inform the development of the 'future direction' of NHS Borders and to inform our organisational strategy for the next five years; giving us an opportunity to reconnect with our staff and communities, provide a clear vision of where we are going and link this to our values. Through a combination of pop-up conversations which took place across the entire Borders region (including in supermarkets, libraries, leisure centres as well as NHS sites) and with an option to fill in an on-line questionnaire, a total of 1,347 responses were received. This data has been interpreted and analysed and is informing future strategic planning. NHS Borders has already launched its overarching Organisational Strategy[1] with key enabling strategies to be developed; Clinical, Digital, People, Estates and Financial. The aspiration is to weave anti-racism/other anti-discrimination measures throughout the suite of key organisational strategies & policies in a mainstreaming fashion[2].

Governance and Assurance - The work of the Anti-Racism Committee will be led by the Director of People and Culture and will be reported into the Staff Governance Committee and the Clinical Governance Committee, and there onwards to the full Board, as appropriate.

National Alignment and Assurance

This Anti-Racism Plan has been developed in line with Scottish Government and NHS Scotland Anti-Racism Plan guidance and national expectations for NHS Boards. Progress against the plan may be subject to national sharing, review or assurance activity, and learning will be shared as appropriate to support wider system improvement. NHS Borders will use established governance and reporting arrangements to provide transparency and assurance at local and national levels.

[1] NHS Borders Organisational Strategy - Page 8 - *"…NHS Borders is committed to championing the creation of an inclusive culture that reaps the benefits from this diversity."*

[2] NHS Borders Equality Mainstreaming Report– Page 2 – see outcomes 1 & 2.

Delivery Framework

This Delivery Framework sets out how NHS Borders will translate the strategic outcomes of the Anti-Racism Plan into practical action across governance, workforce and service delivery. It brings together clear objectives, current status and supporting evidence to provide transparency, accountability and assurance. The framework reflects a phased and proportionate approach, recognising areas where progress has already been achieved, where work is ongoing, and where further development is required. Progress will be monitored through established governance arrangements, with oversight from senior leadership and the Board, and will remain responsive to learning, lived experience and emerging evidence.

Delivery Objectives		Status
1. Governance		
1.1	**To appoint an Executive Lead for developing and progressing the Anti-Racism Plan.** Director of HR (people element) supported by Director of Public Health (clinical service element).	✓ Achieved
1.2	**To establish an Anti-Racism Committee (ARC) which represents key stakeholders inside NHS Borders and is inclusive of workers from minority ethnic backgrounds.** Contributors identified and 2025/2026 dates being organised. Terms of Reference still to be agreed. Further participation/engagement sought from clinical staff. Input also to be sought from independent contractor community (General Practice, GDPs, Community Optometry and Pharmacies).	✓ Achieved
1.3	**NHS Borders Anti-Racism Plan 2025-2026 to be presented to early 2026 Board for formal approval.** Draft Anti-Racism Plan to be reviewed/endorsed by Staff Governance Committee, Executive Team and delivery Group before agenda item at February 2026 Board.	In Progress
1.4	**Delivery of the Anti-Racism Plan will be prioritised by embedding agreed actions into existing team objectives, workplans and performance reporting, using established governance arrangement.** Enabled and supported by HR, Public Health, Planning & Performance, and Quality Improvement services.	In Progress

Delivery Objectives		Status
2. **Workforce** - to make NHS Borders an equitable place to work for ethnically and culturally diverse members of staff.		
2.1	**To continue to attract and retain talent from around the world and make all individuals feel part of a Team Borders approach.** NHS Borders has recruited 100+ new International Recruits from India, the Middle East, Myanmar, rest of Europe and Africa over the last 3 years and word of mouth/tell a friend has been a substantial component of that success. The availability of short-term social housing for key public sector workers and the cost of purchase/rental market can make Scottish Borders an attractive proposition for people moving to the UK or moving from higher costs parts of the UK such as the South-East of England. NHS Borders also works hard to assimilate new workers into the workforce and region with a comprehensive induction/onboarding program. The onboarding process is under ongoing review and development and has included advice and practical support in setting up UK bank accounts, joining GPs/GDPs, social events and supported travel/subsistence to Objective Structured Clinical Examination (OSCE) events. This has all been facilitated by contributions from Training & Professional Development, HR/OD and Facilities. Earlier this year (May 2025) NHS Borders was awarded the prestigious NHS Scotland Pastoral Care Quality Award in recognition of our hard work on international recruitment and our commitment to supporting our international staff.	✓ Achieved
2.2	**To create and maintain the culture where other NHS Borders staff are culturally aware, accommodating and respect the diversity of personnel around them.** A combination of positive staff communications (stories/achievements) and ongoing engagement/open discussion with NHS Borders' Compassionate Leadership Program, with its Equality & Diversity module. Ongoing consideration of additional equity and cultural awareness (non-bias) training including in Recruitment.	In Progress

Delivery Objectives		Status
2. **Workforce** - to make NHS Borders an equitable place to work for ethnically and culturally diverse members of staff.		
2.3	**To continually gather and evaluate key workforce datasets regarding race & ethnicity data to make sure that NHS Borders' workforce reflects the communities it serves and acts as a fair & exemplary employer, standing ready to effect any remedial action if there is quantitative/qualitative evidence of staff from racialised minorities being treated in a less favourable manner. Included in this objective is compliance with the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.** Please see Appendices 1 and 2. Scottish Borders total population (including children) is 1.9% Non-White. NHS Borders workforce is 6% Non-White. NHS Borders is a significant employer of staff from racialised minorities. Through commitment to the NHS Borders Equality Mainstreaming Plan, the Equality, Diversity and Inclusion in Employment Workplan and ongoing development of the People Dashboard/Metrics, these matters attract ongoing analysis and attention. Work to reduce "Prefer not to say" through staff engagement.	In Progress
2.4	**To publicise developmental/career progression opportunities effectively for all staff and to engage in positive action, where appropriate, to make sure that staff from racialised minorities feel no less favourable treatment in gaining skills and pursuing promoted opportunities.** Through work known as Social Compact, NHS Borders is embarking upon a program of reminding the workforce about Staff Benefits, the HR Policy Framework, Training & Development opportunities and opportunities for Networking. There will be particular bespoke engagement with NHS Borders' Staff Networks including the Ethnic Minority Forum.	In Progress
2.5	**To run reverse mentoring from Board/Executive Team level and into the wider workforce, including around race.** Reverse mentoring for race is where employees from diverse racial or ethnic backgrounds mentor more senior employees, particularly those in leadership positions who may/may not be from a racialised minority themselves. This approach helps senior leaders gain a deeper understanding of the experiences and perspectives of their colleagues from different racial and ethnic groups, fostering greater awareness of potential barriers and promoting a more inclusive workplace. The senior leader can also impart knowledge and wisdom in the other direction.	In Development

Delivery Objectives		Status
3. **Service Delivery** - to eliminate unacceptable racial disparity for minority ethnic communities and improve trust & confidence in our services.		
3.1	**To improve the reporting & recording of race/ethnicity of Service Users/Patients, incorporating a campaign to help staff understand the significance of such recording and to track progress in this area.** NHS Borders has been progressing its new Clinical Strategy over the last six months and this will be supported by associated enabling strategies such as Digital, Estates and People. Better data entry around service user ethnicity is a recognised area in need of investment of time & energy within Health Records.	In Development
3.2	**To actively & respectfully involve minority ethnic people in identifying immediate challenges and priorities for Service Improvement with specific regard to:** • **Type 2 Diabetes** • **Cardiovascular Disease** • **Perinatal Care** • **Mental Health** To complete thorough Equality Impact Assessments in these clinical areas by Summer 2026 in order to inform any necessary changes to or development/delivery of services. This is a work area associated with Public Engagement, Public Health and the Integrated Joint Board. NHS Borders may also wish to look at the area of Pain Management.	In Development
3.3	**Ensure that children and young people from racialised minorities experience equitable access to healthcare and have their rights upheld in line with the UNCRC Act 2024.** Embed children's rights and non-discrimination into all service planning and redesign by explicitly assessing the impacts on children and young people from racialised minorities through Equality Impact Assessments. Ensure that the voices of children and young people are heard and considered in decisions affecting their care, in accordance with Articles 2 and 12 of the UNCRC.	In Development

Delivery Objectives		Status
4. **Communication and Engagement** – to ensure our imagery and language is reflective of the people we serve and to involve minority ethnic communities living in the Scottish Borders in the development of services.		
4.1	**NHS Borders is undergoing significant transformation and has been engaged in a large-scale public consultation exercise over the last nine months. Care & attention will be paid to ensuring that imagery and language is reflective of the people served.** NHS Borders has been progressing its new Clinical Strategy over the last six months and this will be supported by associated enabling strategies such as Digital, Estates and People.	In Progress
4.2	**NHS Borders will provide a named route for raising racism-related concerns (staff and service users).** Commitment to tag racism related complaints, review themes and actions via ARC; and provide feedback on learning and change.	In Development
5. **Working in Partnership** – to work collaboratively with other public & third sector providers locally and nationally, to improve working lives and improve the services we deliver.		
5.1	**Primarily through the Health & Social Care Partnership, NHS Borders will continue to engage with the Integrated Joint Board / Scottish Borders Council and Third Sector/other counterparts to eliminate unlawful discrimination, harassment, victimisation and any other unlawful conduct, to advance equality of opportunity between people and to foster good relations between people.** NHS Borders will engage with all of its partners to fulfil both the general and specific duties of the Equality Act 2010.	In Progress

Key Performance Indicators (KPIs) from Delivery Outcomes		
i.	HR	To analyse the demographic breakdown of the NHS Borders workforce through a race/ethnicity lens and observe and report on any changes/fluctuations to both the Anti-Racism Committee and Staff Governance Committee. This will look at success levels at recruitment, career progression, access to training opportunities and also involvement in HR Policy matters (including use of Discipline, Grievance and Bullying & Harassment policies).
ii.	HR / Communications	To survey/hold focus groups with workers from racialised minorities (including recent International Recruits) to test for levels of job satisfaction and fulfilment and to identify any workplace difficulties. This will also include analysis of iMatter data by ethnicity and where any matters of concern are identified, plan and make efforts to improve the situation.
iii.	HR / OD / Public Health	To consider the need for further staff training (perhaps with a focus on line managers in the first instance) with an aim to increase understanding of the particular challenges which are faced by minority ethnic staff and service users, and to enhance understanding & empathy. This may include Unconscious Bias and Active Bystander training and may include collaboration with neighbouring Health Boards. Numbers of attendees will be recorded, by work area. All cultural competency and anti-racism training will include modules on UNCRC Act 2024 obligations, focusing on listening to children, respecting cultural identity, and trauma-informed care for minority ethnic families.
iv.	Training & Professional Development / HR / Corporate Departments	To take positive action to bring training & development opportunities to the attention of minority ethnic staff by use of a targeted distribution list and point of contacts to describe the courses and advise how best to access them. Numbers of e-mails / posters issued will be recorded, as will uptake of training by ethnic minority staff.
v.	OD	To establish a pathway/vehicle for reverse mentoring between members of the Executive Team & minority ethnic staff and record this.

Key Performance Indicators (KPIs) from Delivery Outcomes		
vi.	Planning & Performance / Digital / Communications	To improve the reporting & recording of race/ethnicity of Service Users/Patients, incorporating a campaign to help staff understand the significance of such recording and to track progress in this area. NHS Borders to agree a target for capturing race/ethnicity data of service users and set a trajectory for improvement.
vii.	Public Health / Planning & Performance	To actively & respectfully involve minority ethnic people in identifying immediate challenges and priorities for Service Improvement. This will include under Article 12 of the United Nations Convention on the Rights of the Child the fact that every child has the right to be heard in matters affecting them. This links to development of the new Clinical Strategy.
viii.	Occupational Health / Coaching Network / Ethnic Minority Forum	To be available to sensitively support all staff who may have suffered past experiences of trauma including those who may have come to Scotland from countries experiencing war and conflict. Also, to be available to support minority ethnic staff who may be engaged in HR Policy matters such as Discipline, Grievance and Bullying & Harassment and to use expert advisers from within NHS Borders ethnic minority communities to engage with/on panels and investigations.
ix.	Public Health / HR / Trade Unions	To ensure that Equality and Human Rights Impact Assessments are performed for any service changes affecting staff and service users, taking into account any significant needs of those from racialised minorities including children from racialised minorities.
x.	Public Health / Planning & Performance	To review & record levels of translating and interpreting inside NHS Borders and improve staff understanding of how to access this facility. Ensure all public-facing materials and internal communications reflect diverse backgrounds. Develop child-friendly resources explaining their rights and how they can give feedback on services.

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Glossary

Racism is a complex issue that intersects with other characteristics such as age, disability, and socio-economic status. While the Oxford Dictionary defines racism as '*Prejudice, discrimination, or antagonism directed against someone of a different race based on the belief that one's own race is superior.'*, this is a simplified explanation. Concepts such as discrimination and racial superiority are not always straightforward, and views on these concepts evolve over time with changing social contexts and new ways of thinking.[3]

The definitions in this section are provided to help establish a shared understanding as we work collectively to strengthen equity, inclusion, diversity and anti-racism across NHS Borders. They align with the Equality Act 2010 and the Public Sector Equality Duty, and are intended to support consistent language, learning and reflection. This is not a comprehensive glossary, but a practical guide to help build a shared understanding as we progress this work together.

Anti-Racism: is the active practice that uses everyday behaviours and shared responsibility to challenge racism. It requires accountability, listening to lived experience and taking action to promote fairness, equity and inclusion.

Bias: is patterns in thinking that can influence decisions and behaviour, often without awareness. Bias can influence decisions and behaviours in ways that create inequality.

Cultural Compassion: as set out in the NHS Borders Compassionate Leadership approach, is a stance towards understanding culture that recognises diversity, difference and lived experience. It requires a commitment to lifelong learning, ongoing self-reflection on one's own assumptions and practices, and a willingness to be comfortable with "not knowing". Cultural compassion also involves recognising and responding to the health inequalities that exist between patients, communities and staff, and approaching interactions with openness, humility and empathy.

Cultural Safety: Cultural safety refers to an environment in which individuals feel respected, valued and safe from discrimination, bias or harm related to their identity, culture or background. It requires organisations and individuals to recognise power imbalances, challenge behaviours and systems that cause harm, and take responsibility for creating conditions where people can speak up, participate fully and receive care or work without fear of prejudice or exclusion. Cultural safety is defined by the experience of those receiving care or working within the organisation, rather than by the intentions of those providing it.

[3] Racism in Scotland — CRER - Coalition for Racial Equality and Rights Coalition for Racial Equality and Rights works to eliminate racial discrimination and harassment and to promote racial justice across Scotland.

Discrimination: Discrimination refers to an act, communication or decision that results in the unfair treatment of an individual or group. This may involve imposing a burden on someone, or denying them a right, privilege, benefit or opportunity enjoyed by others. Discrimination can be direct and intentional, or indirect and unintentional, where rules, practices or procedures appear neutral but result in disadvantage for certain groups. Discrimination is best identified by those who experience it, recognising that there can be a difference between intent and impact.

Diversity: Diversity refers to the inclusion and involvement of people from a wide range of backgrounds, identities and lived experiences. Diverse groups bring different perspectives and ways of thinking, which can lead to more informed decisions and better outcomes. However, these benefits are only realised when individuals feel able to be themselves and do not feel pressure to suppress aspects of their identity. Diversity is therefore about valuing, respecting and encouraging a broad range of experiences, viewpoints and perspectives.

Equality: Equality refers to the practice of ensuring that individuals are treated the same and are not disadvantaged on the basis of protected or personal characteristics. Equality focuses on providing the same opportunities and standards of treatment for all, without necessarily accounting for differing needs, circumstances or barriers.

Equity: Equity is concerned with fairness and justice in both processes and outcomes. Unlike equality, equity recognises that treating people the same does not always result in fair outcomes. Achieving equity often requires different approaches, targeted support and the redistribution of resources to address barriers and create a level playing field, enabling all individuals and communities to thrive.

Health Disparities: Health disparities are differences in access to healthcare, experiences of care or health outcomes that are systematic, patterned and preventable. These differences are often linked to social, economic and structural factors, including discrimination and inequality, and disproportionately affect certain population groups.

Health Equity: Health equity focuses on the health system's ability to provide fair and appropriate care so that everyone has the opportunity to achieve their full health potential. It recognises that different people and communities have different needs and barriers, and that equitable care may require tailored approaches to ensure high-quality outcomes, regardless of where people live, what they have or who they are.

Hierarchical Discrimination: (in employment) refers to a pattern in which different racial, ethnic, or social groups experience unequal treatment and unequal access to opportunities at varying levels of severity, creating a tiered structure of workplace disadvantage, where some groups face multiple and compounding barriers (such as in recruitment, promotion, pay, training access, performance management, and workplace culture), while others experience

only moderate disadvantage, and some encounter minimal or no barriers at all or may even benefit from favourable assumptions or established networks.

Inclusion: Inclusion is the active practice of recognising, welcoming and making space for diversity. An inclusive organisation values and enables the full participation of people from all backgrounds, ensuring that differences in identity, experience, thought, skills and talent are respected and contribute meaningfully to decision-making, culture and outcomes.

Intra-ethnic discrimination: Refers to discrimination within or between ethnic minority groups, including tensions based on culture, nationality, language, caste, colourism, etc.

Microaggression: Refers to everyday words or actions that can reinforce exclusion or inequality, often unintentionally. There are three types:

- *Microassault – "That accent might be confusing for patients. Are you sure this is the right area for you?"*
- *Microinsult – "You're surprisingly confident for someone new to the system."*
- *Microinvalidation – "I don't see colour, professionalism is all that matters here."*

Racism: is behaviours, practices, and systems that create or maintain unequal outcomes based on race.

Trauma-Informed Care: Trauma-informed care is an approach to healthcare that recognises the possibility that individuals may have experienced trauma, such as abuse, neglect, discrimination or violence. It prioritises physical and psychological safety, choice, control and empowerment, and seeks to avoid re-traumatisation by understanding how past experiences may affect people's interactions with services, staff and systems.

> "Very few people could **be fairly described as 'racists'**, but anyone can behave or think in a racist or xenophobic way. To stop racism, we need to **become** anti-racist as a society. This means **changing the way we think and act and being prepared** to **challenge** others to do the same.
>
> *- Racism in Scotland (CRER)*

Moving Forward

Racism causes harm to individuals and communities and undermines trust in organisations and public services. It can make staff feel unsafe, limit wellbeing and belonging, and deter people from seeking the care and support they need. Racism also affects the culture, effectiveness and reputation of our workplaces and services.

Being anti-racist means going beyond simply rejecting racism in principle. It requires active commitment, ongoing learning and the willingness to challenge behaviours, practices and systems that cause harm, even when they do not directly affect us. Through this Anti-Racism Plan, NHS Borders commits to embedding anti-racist practice across leadership, workforce and service delivery, listening to lived experience, and holding ourselves accountable for meaningful and sustained change.

> “This has to be a *working document* — one that evolves as we listen, learn and respond.

NHS

BORDERS

2026

Appendix 1: Scotland's Census 2022, Scottish Borders Council Area, Whole Population

Ethnic Group	Count	Percentage
All People	116,821	100.0%
White: Total	114,602	98.1005128%
Mixed or Multiple Ethnic Group	843	0.7216168%
Asian, Asian Scottish or Asian British: Total	802	0.6865204%
African: Total	167	0.1429537%
Caribbean or Black: Total	82	0.0701929%
Other Ethnic Groups: Total	329	0.2816274%

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Resources & Performance Committee Minutes**
Responsible Executive/Non-Executive:	**J Ayling, Chair, Resources & Performance Committee**
Report Author:	**I 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 5 March 2026.
- Extraordinary Resources & Performance Committee 19 March 2026

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Resources & Performance Committee minutes 15.01.26
- Appendix No 2, Resources & Performance Committee minutes 05.03.26

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 15 January 2026 at 9.00am via MS Teams.

Present: F Sandford, Chair
J Ayling, Non Executive
L O'Leary, Non Executive
L Livesey, Non Executive
D Parker, Non Executive
P Williams, Non Executive
P Moore, Chief Executive
S Bhatti, Director of Public Health
J Smyth, Director of Planning & Performance
O Bennett, Interim Director of Acute Services
K Lawrie, Partnership Chair

In Attendance: I Bishop, Board Secretary
K Rodgers, Deputy Director of Finance

1. Apologies and Announcements

1.1 Apologies had been received from J Pepper, Non Executive, L McCallum, Medical Director, S Horan, Director of Nursing, Midwifery & AHPs, G Clinkscale, Interim Director of Urgent Care, Community Services & Mental Health, A Bone, Director of Finance, L Jones, Director of Quality & Improvement and J McLaren, Non Executive.

1.2 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 6 November 2025 were approved.

4. Matters Arising

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

5. Annual Delivery Plan 2026/27

5.1 J Smyth set out the normally expected sequence for the Annual Delivery Plan (ADP) development with guidance from the Scottish Government expected in October/November each year. She emphasised that although the expectation remained for a full ADP submission, the national commissioning guidance had been delayed until 19 December, leaving only 68 working days until the end of March to deliver both the regional and local plans.

5.2 In regard to the sub national planning and commissioning framework she explained that 2024/25 had been intended as a transitional year, with Scottish Government signalling a move toward a Sub-National Planning and Commissioning Framework, dividing Scotland into an East Region and West Region, each with 4–5 priority workstreams (orthopaedic elective care, digital front door, cardiology, business systems, other cross regional reforms). Those priorities had been partially communicated in September and October, but the detail remained incomplete. The Committee heard that additional requirements, such as the new theme for "Rural and Island" Boards, had been added, which required Boards to incorporate the theme into their regional submissions. She acknowledged that guidance remained fluid and additional national clarifications were expected.

5.3 J Smyth stressed that although NHS Borders had committed locally to integrating service planning, workforce planning, and financial planning into a cohesive cycle, the national timelines effectively prevented the usual deep engagement with local services, Area Clinical Forum and Area Partnership Forum. She reiterated that while NHS Borders retained local governance requirements, submissions to the regional planning structures had to be signed off locally.

5.4 Particular concern was expressed regarding the equality impact assessments (EQIAs) for regional plans. She highlighted the strong feedback from planners across Scotland that EQIA expectations could not realistically be met within the timeline. The Scottish Government were clear that it was for regional planning boards to raise concerns at the National Planning Forum.

5.5 P Moore described the aggregated complexity across regional structures, national asks, local strategic priorities, and concurrent financial pressures. He highlighted that each workstream required clear scoping, timelines, and resource modelling.

5.6 J Smyth reassured the Committee that NHS Borders would still deliver its local ADP, separate from the regional plan, focusing on Borders' own priorities, clinical strategies and operational needs. She further advised that the Scottish Government may issue additional commissions for local ADPs and any new requirements would be integrated once known. She assured the Committee that NHS Borders remained committed to shaping regional outputs to benefit local populations and maintain local control where possible.

5.7 Discussion followed which focused on: uncertainty in commissioning expectations; risk of losing local clinical momentum; insufficient consultation with local authorities and Integration Joint Boards; workforce pressures; regional variation in interpretation of planning requirements; underlying inequalities risks; three intersecting pressures of extremely compressed timeframe to deliver a robust regional plan by March, the added layers of complexity introduced by multiple thematic workstreams (orthopaedics, remote & island, population health, deprivation, digital, workforce, finance) and the interaction with the Regional Joint Board annual plan or strategy,

which had to be considered concurrently; operational realities and the risk of delay; and financial pressures and upstream prevention.

5.8 Following the broader sub-national planning discussion, the Committee moved into a focused examination of Orthopaedics, one of the most operationally significant and clinically high-impact regional workstreams within the emerging East Region framework. The conversation linked local service delivery, regional redesign ambitions, productivity improvements, and the risks and opportunities for NHS Borders. O Bennett confirmed that the East Region Orthopaedic Workstream had indeed held its initial meeting the previous day which had focused on organisational and structural elements. He explained that the intention was to bring relevant regional clinical leads into the group for its next phase, which would include: surgical leads; anaesthetic leads, and AHP (Allied Health Professional) leads. O Bennett emphasised that those individuals were already linked to national improvement structures and therefore formed the most logical initial clinical group for a region-wide improvement programme.

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

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance on systems and processes and limited assurance on outcomes.

6. Integrated Performance Report

6.1 J Smyth introduced the report which was as at end of November 2025 and the updates that had been made to the report and issued to the Committee earlier in the week.

6.2 O Bennett provided an overview of the acute content of the report in regard to unscheduled care and system flow and planned care. In regard to urgent and unscheduled care he provided an extensive and operationally detailed update on the organisation's emergency care performance, system pressures, and the impact of ongoing improvement programmes. This agenda item addressed multiple interconnected domains, including ED 4-hour performance, 12-hour breaches, hospital flow, bed occupancy, length of stay, frailty unit, integrated discharge team, expansion of Home First and Hospital at Home, delayed discharges, ambulance handovers, and key initiatives intended to alleviate pressure on the system.

6.3 In regard to planned care performance O Bennett provided a detailed and multi-layered update on progress toward national and local targets which included: outpatient long waits (elimination of 52 week waits by all Boards was expected by 31 March 2026); improvements in Dermatology waits; Treatment Time Guarantee (TTG) performance which had slowed especially in ENT; long-wait elimination; specialty-specific risks; confidence in orthopaedic waits (25% more arthroplasties delivered year-on-year; high-volume weekend lists); ultra long waits had been reduced; and operational pressures affecting delivery. The item highlighted both significant achievements and material risks which required active management over the final quarter of the financial year.

6.4 O Bennett also confirmed a correction in regard to Theatre utilisation and confirmed that theatre utilisation percentages had been under-reported previously because Borders' metric incorrectly included turnaround time between cases. When

recalculated in line with national methodology (excluding the accepted 20–35 minutes), utilisation rose by 14%–15% points, placing Borders close to the highly regarded 85% benchmark. This correction significantly repositioned surgical productivity narratives and would be reflected in future reports.

6.5 In regard to diagnostic performance, O Bennett highlighted significant progress over the past year and clarified areas where further improvement was required. Diagnostics performance was a core national metric, typically measured by the percentage of patients who received a diagnostic test within six weeks of referral. In particular, MRI and CT performance had risen into the high 90% range. Despite strong overall performance, he confirmed that one modality continued to limit NHS Borders' aggregated diagnostic performance, non-obstetric ultrasound (NOUS). He emphasised that:

6.6 O Bennett highlighted to the Committee the substantial improvement across the cancer pathways over the course of the current financial year and provided context for the temporary fluctuations observed in the November report.

6.7 Further discussion focused on the need for clearer visualisation of patient flow data; proposed escalating reporting structures to ensure actions directly correlated to performance shifts; exploration of ENT waiting times mitigation; considerable operational effort across radiology departments; that an improvement plan was in place for ultrasound performance; and the interconnectivity between, diagnostics performance, cancer treatment delays, workforce pressures and planning uncertainties associated with sub national arrangements.

6.8 L Livesey raised an important query to ensure that the mental health aspects of the Integrated Performance Report (IPR) were not overlooked, especially given the breadth of performance indicators and the organisation's growing scrutiny in that area. She enquired if there was an update on the leadership of Workforce and HR, both of which were intimately connected to mental health service capacity, sustainability, and mandatory national requirements.

6.9 P Moore commented that he was in active discussions with two potential interim candidates for the HR leadership role, one of whom had been identified as a strong fit. He confirmed that contractual arrangements were being finalised and expressed hope to make an announcement early the following week.

6.10 P Moore than provided a substantive update on 2 critical service areas: Child and Adolescent Mental Health Services (CAMHS) where performance had been relatively strong, with the service managing to maintain progress despite winter pressures and staffing challenges; and Neurodevelopmental (ND) Pathway where significant progress had been made in reducing the ND backlog, with waiting times around 7–9 months, which compared favourably to many Scottish Boards where waiting times could stretch to 4–5 years. He also emphasised that this improvement was achieved through consistent operational work and prioritisation, although the pathway remained under national attention. He further briefed the Committee in regard to the introduction of "engagement appointments" and the Scottish Government had signalled that Boards may be escalated through assurance processes if they did not comply with engagement-appointment expectations.

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

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance on systems and processes and limited assurance on outcomes.

7. Finance Report

The **RESOURCES & PERFORMANCE COMMITTEE** noted the item was deferred.

8. Financial Plan Update

The **RESOURCES & PERFORMANCE COMMITTEE** noted the item was deferred.

9. Any Other Business

9.1 **Industrial Action:** O Bennett advised that whilst Industrial Action had been avoided the preparation exercise had enabled an important review of the organisation's preparedness for such an event. He emphasised that NHS Borders had been "well prepared" for the industrial action and that a robust operational plan had been fully developed which would maintain: all essential emergency and urgent services; safe levels of staffing across key clinical environments; continuity of critical pathways such as cancer, obstetrics, and emergency surgery; and as much planned elective activity as could safely be sustained. He commented that, despite the severity of the potential disruption, the organisation's planning had been strong and comprehensive. One key highlight of his update was that, under the prepared plan, NHS Borders would have been able to sustain 80% of its planned elective care activity even during the strike period. He further commented that while the organisation hoped not to need such a plan again in the near future, the existence of a tested strategic and operational model placed Borders in a stronger, more prepared position for any subsequent national or local disputes.

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

10. Date and Time of Next Meeting

10.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 5 March 2026 at 9.00am via MS Teams

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 5 March 2026 at 9.00am via MS Teams.

Present:
F Sandford, Chair
J Ayling, Non Executive (Chair)
L O'Leary, Non Executive
L Livesey, Non Executive
J Pepper, Non Executive
P Williams, Non Executive
J McLaren, Non Executive
A Bone, Director of Finance
L McCallum, Medical Director
S Bhatti, Director of Public Health
J Smyth, Director of Planning & Performance
A Keen, Director of People & Culture
O Bennett, Interim Director of Acute Services
G Clinkscale, Director of Urgent Care, Community Services & Mental Health
L Jones, Director of Quality & Improvement

In Attendance:
I Bishop, Board Secretary
L Henderson, Communications Officer
J Dickson, Digital Programme Manager
K Messer, Digital Operations Manager
K Bryce, Digital Transformation Manager

1. Apologies and Announcements

1.1 Apologies had been received from D Parker, Non Executive, P Moore, Chief Executive, and S Horan, Director of Nursing, Midwifery & AHPs.

1.2 The Chair welcomed J Pepper, Non Executive and A Keen, Director of People & Culture to their first meeting of the Committee.

1.3 The Chair noted that the Board Secretary was trialling the use of copilot transcription to support minute production, noting it remained a developing process that still required manual review.

1.2 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 15 January 2026 were approved.

4. Matters Arising

4.1 **Action 2025-4:** S Bhatti confirmed the report had been completed and would be presented to the Clinical Governance Committee ahead of presentation to the next meeting of the Resources & Performance Committee.

4.2 **Action 2025-5:** O Bennett reported that in regard to Length of Stay metrics, enhanced oversight structures were in place, including a weekly group specifically focusing on acute 14-day stays. The improved reporting format would be implemented from the April data (June report), aligned with organisational performance framework changes.

4.3 **Action 2025-6:** O Bennett clarified that no waiting list or backlog existed for obstetric ultrasound, as appointments were allocated directly at obstetric clinics, unlike non-obstetric ultrasound where waiting lists persisted. It was agreed to close the action on the action tracker.

4.4 **Action 2025-7:** G Clinkscale suggested that Action 2025-7 and 2025-8 be consolidated into the Urgent & Unscheduled Care Phase 1 Review report. Progress was noted regarding Home First demand tracking, digital solution development, manual systems, and reablement capacity expansion. Committee members highlighted the risks created by a lack of baseline capacity visibility.

4.5 **Action 2025-9:** The Chair noted that the action was complete. The Chair suggested an update on the LIMS programme be provided to the next meeting.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Action 2025-6.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to merge Action 2025-7 and 2025-8 together.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to receive an update on the LIMS programme at the next meeting.

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

5. Sub National Planning East Region Update

5.1 J Smyth presented a comprehensive update on progress across the East Region planning programme. The Committee noted that NHS Borders' executive leadership team was significantly involved across multiple workstreams, with several senior staff leading regional groups. The challenging national timeline required submission of a draft regional plan by the end of March, which had prompted the scheduling of an additional Private Board session on 19 March.

5.2 Key constraints included:

- Workforce workstreams remained delayed pending national agreement on regional workforce roles.
- Digital Front Door and MyCare app elements would follow a separate approval timeline due to outstanding national dependencies.
- Draft plans could not enter the public domain before Ministerial review, complicating traditional stakeholder engagement processes (ACF, APF). Mitigation steps for engagement post-submission were outlined.

5.3 Further discussion centred on:

- Risk of dominance by NHS Lothian within regional planning: members acknowledged the concern but emphasised opportunities for Borders to showcase strengths (Hospital at Home, elective optimisation, community hospital transformation).
- Quality and comparability of shared data: concerns raised around orthopaedic benchmarking and ensuring that analyses compared like-for-like; representations would continue through workstream participation.
- Need for clear single organisational roadmap aligned to the Clinical Strategy.
- Workforce sustainability: shortages across clinical specialities highlighted the necessity of new joint service models.

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

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance from the report with the caveat that the Committee were aware of very significant time pressures and the risk of not producing accurate information and data and completing tasks on time.

6. Integrated Performance Report

6.1 J Smyth introduced the report with data as at the end of January and reminded the Committee that a major redesign of the performance framework was underway and a new Integrated Performance Report (IPR) format would be implemented from June 2026 onwards.

6.2 O Bennett provided an update in regard to unscheduled care where he reported mixed performance. The 4-hour standard performance had improved slightly but dipped in January due to high attendances, increased admissions, flu-related pressures and infection and prevention control constraints. The 12-hour standard had remained a major outlier nationally, with 13.5% of attendances breaching. Improvement was expected as Home First, Frailty Assessment Unit and urgent and unscheduled care changes stabilised. Length of stay overall was trending positively and delayed discharges were expected to fall back to the 40s in March.

6.3 In terms of planned care significant progress was reported with an 81% reduction in 52-week outpatient waits; 73% reduction in long surgical waits and near elimination of 2-year waits. However, dermatology and orthopaedics remained constrained by workforce shortages.

6.4 In regard to cancer performance, dermatology referrals had surged and Lothian's festive slowdown had increased the backlog, though numbers had since stabilised.

6.5 G Clinkscale reported on the need to create more reablement capacity; working with Quality Improvement on the Home First service on how that was operating and creating more capacity in that expanded service; freed up AHP colleagues were able to provide more rehabilitation; and the GP walk in service which was aiming to open at the end of April. He further highlighted mental health data and commented that Child Adolescent Mental Health services (CAMHS) 18-week delivery was at 100%. Neurodevelopmental waiting times remained long due to prioritisation of treatment waits and psychological therapies showed marked improvement (89% within 18 weeks).

6.6 Further discussion emphasised:

- Linking ED "bounce-backs" with length-of-stay data.
- Need for joint dashboards with the Integration Joint Board.
- Data quality constraints in community and mental health, with dashboards expected over the next six months.

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

The **RESOURCES & PERFORMANCE COMMITTEE** agreed that a deeper dive into data at the front door was required.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance in terms of systems and process and limited assurance in terms of outcomes.

7. Strategy Implementation Plan

7.1 J Smyth provided an overview of the content of the paper and highlighted implementation planning for the Clinical Strategy. The approach focused on engaging clinical teams to identify priority areas for 2026/27, aligning enabling strategies and ensuring coherent organisational delivery. A revised Annual Delivery Plan would be presented to the Board in June 2026.

7.2 Discussion focused on:

- Enabling strategies originally due in April had been deferred until June, adjusted to reflect implementation priorities.
- The organisation would produce a single prioritised roadmap to align clinical, regional and national priorities.
- Concerns were noted about outdated health-behaviour assumptions (e.g., "leaflets for self-help"), with agreement that future iterations must embed behavioural-science-based approaches.
- The plan provided an opportunity to reset governance and avoid fragmented initiatives.

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

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

8. Digital Refresh Programme

8.1 J Smyth provided a substantive update marking one year of the Digital Refresh Programme. The programme had delivered significant cybersecurity, infrastructure and resilience improvements, despite constrained staffing and an expanded scope.

8.2 She highlighted several achievements:

- Resolution of majority of high-priority cyber and infrastructure risks.
- Material uplift in device security standards.
- Strengthened Disaster Recovery and Business Continuity position.
- Significant capital allocation uplift to £2m following successful national bid, enabling major datacentre upgrades.
- Completion of foundational work enabling the forthcoming Digital Enabling Strategy.

8.3 Further discussion focused on the rationale for formally retiring the programme on 31 March 2026, transitioning remaining work into the new Digital Foundations Programme and Business As Usual (BAU) structures. That would align digital governance with the new organisational Portfolio framework. Capital investment in digital and slippage identified nationally.

8.4 The risks identified included:

- Need to ensure strong and consistent clinical engagement in digital governance.
- Ensuring that digital capacity keeps pace with transformation demands emerging from the Clinical Strategy.
- Embedding new Programme Board arrangements from April.

The **RESOURCES & PERFORMANCE COMMITTEE** noted strong progress and acknowledged significant efforts from digital staff despite capacity challenges.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the progress made on the Digital Refresh Programme, endorsed the retirement by 31 March 2026 along with the transition of residual activities to the Digital Foundations Programme and BAU, including conversion of the Programme Board to the Digital Portfolio Board from 1 April 2026.

A further update on progress would be provided during 2026/27 once the Strategic Risk relating to Digital Infrastructure had been reviewed and once the new Portfolio arrangements had bedded in.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance in terms of systems and process and limited assurance in terms of outcomes.

9. R&PC Annual Report 2025/26

The **RESOURCES & PERFORMANCE COMMITTEE** noted the current draft report and approved final sign off by the Chair after the elements from the 5 March 2026 meeting had been included.

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

10. Finance Report

10.1 A Bone presented the January 2026 financial position. The Board was forecasting delivery of the planned £10m deficit target, with the year-to-date position at £8.54m overspent. Additional non-recurring benefits had emerged (new medicines fund, CNORIS adjustments, and discussions with Scottish Government regarding Integration Joint Board (IJB) transformation support).

10.2 In terms of key issues he highlighted:

- Significant overspend on medical locum costs, reversing last year's progress. Workforce shortages, unplanned consultant absence, and insufficient regional support were major contributors.
- Savings delivery and identification remained below target, and vacancy-related underspends continued to support financial balance.

10.3 Further discussion centred on the relationship between health and council financial pressures, particularly in relation to IJB budgets and adult social care capacity.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed to receive a Board-level deep-dive into medical agency cost drivers and workforce vulnerabilities across all professions potentially at a Private Board session in March/April.

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

YTD Performance	£8.54m overspend
Outturn Forecast at current run rate	£10.25m overspend
Projected Variance against Financial Plan (current run rate)	£2.55m improvement
Actual Savings Delivery (current year effect)	£7.53m (actioned)
Projected gap to Forecast	Best Case £10.00m (Forecast Q3) Worst Case £10.25m (trend)

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

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

11. Financial Plan Update

11.1 A Bone delivered an overview of the current Financial Outlook, including a summary of progress against the Financial Plan up to this point. The presentation also covered the anticipated timeline for future developments, outlining key milestones and expectations going forward.

11.2 L McCallum highlighted recent discussions in regard to reductions in adult social care provision, both at Upper Deanfield and within residential and home care services, she emphasised that it was crucial to thoughtfully balance the implications of extra funding alongside proposed reductions whilst the approach remain constructive within the IJB framework.

11.3 A Bone commented that recent Joint Executive discussions had addressed on-going budget challenges for both organisations, which highlighted varied approaches and

significant risks. The IJB reserve was expected to grow, enabling an additional contribution this year, likely carried forward rather than spent immediately —minimum estimated at £3m, with potential for more. His focus was on managing allocation risks, closing financial gaps in delegated services, and creating a transformation fund. SBC required at least £6m in savings next year, but current plans did not reflect anticipated health funding streams. Previously, £2m was provided non-recurring, with no on-going commitment; any further action would be within the IJB scope and likely also non-recurring.

11.4 The Institute for Fiscal Studies' annual budget report highlighted that most Scottish Government portfolios received extra funds in 2025-26 due to overspending, supported by unexpected UK Treasury allocations and internal cuts. Health got over £600m, mainly non-recurring, for deficit support and operational improvements, but with no guaranteed renewal. The Institute forecast a 0.6% real-term reduction in health and social care budgets after inflation and social care adjustments. Allocated funds were tied to specific initiatives, like wage increases, and further cuts were expected. Resources would shift toward primary and social care, with hospital funding rising just 0.4%. Savings would drive investment in territorial boards, and two-thirds of public sector savings must come from health and social care, posing major challenges.

11.5 Operational priorities remained broad due to parliamentary timing, without detailed commitments. Recent feedback stressed the need for balanced three-year financial plans, including available deficit support; failing that, plans would be rejected. The previous five-year recovery plan requirement was replaced by new frameworks, now mandating a balanced three-year financial plan with clear recovery actions.

11.6 The updated "15 box grid" framework prioritised prevention and cash benefits, though they were not yet locally implemented. Contract management and transport reviews were now key priorities, aligning with local initiatives. West Scotland had 57% of the budget and two-thirds of the deficit, while East Scotland held 43% and one-third. However, the East's deficit was higher than expected. Scotland's financial gap was £1b pre-savings, reduced to £450m post-savings. Over £600m in health support was added this year, with similar levels likely next year without further savings.

11.7 A Bone reiterated that the financial plan showed no major changes: the gap stayed at £16m into 2026-27, with a £10m deficit target and insufficient savings. Additional savings would be difficult, and new investments must use existing budgets. Creating transformation resources was crucial, and SBC forecasts and IJB reserves presented both risks and opportunities. Given the Board was asked to submit a balanced plan, with a £10m target in the first year and decreasing targets thereafter, he believed it was unattainable given current plans. Consequently, he proposed submitting a plan likely to be rejected by the Scottish Government, pending further actions or an extraordinary meeting to approve or delay submission.

11.8 Discussion focused on: financial plan position in other Health Boards; potential presentation of deficit by population size; closure of Borders View had been reflected in the deficit; nothing assumed at this stage around Community Hospital closure; recurring cost in terms of personnel should be included; understanding where investment or disinvestment was needed to deliver prevention, community-based care and population-based planning; looking for structural changes rather than reductionist changes; moving into multi-skilled people that work alongside teams ie

paramedics that are also nurses – so they have multi-skills rather than just multi-disciplinary teams working together; Buchan Associates report was clear that 40% of bed capacity in community hospitals could be provided by an alternative means and that would be more cost effective; community services review; and building on reablement capacity over the next year.

11.9 A Bone commented that there remained a degree of uncertainty regarding the funding situation. However, the Scottish Government had provided some clarity specifically concerning what could be assumed in terms of funding for the operational improvement plan. Notably, the amount that could be assumed was less than the current level of funding. Whilst it represented a reduction, there were certain caveats that might offer opportunities to mitigate the impact. Therefore, it would not be accurate to state categorically that there would be no funding, as some flexibility may exist. In terms of agenda for change reform, there had been no significant developments; the current understanding remained unchanged. The team continued to work through the detail and the available funding level was known. However, there was uncertainty about the final costs, as they had not yet been determined. In particular, the uncertainty was centred around two aspects that had not been fully explored or resolved at that point.

11.10 A Bone then presented the proposed IJB budget offer and clarified that the proposal was to transfer the allocations received, which generally meant a 2% overall increase, pay awards fully funded if the Scottish Government provided full funding, and agenda for change reform released according to the local risk-based approach. That approach did not grant a direct share of funds; instead, investment was made in positions approved through that plan. If those positions happened to fall more within acute care than primary care (or other areas), that was how the distribution occurred. Funds would be allocated based on the risk assessment. He also clarified that there would not be any new savings targets, but previous years' undelivered targets remained in effect and must be achieved. Cost pressures needed to be managed and existing savings goals met, which were standard yearly assumptions. Deficit support from the Scottish Government for the IJB required a balanced plan from the Board, given a current £16m gap and £10m deficit support available. Full funding of the IJB's deficit depended on closing this gap. Additionally, strategies for reserve use needed review and discussion. Regarding the SBC budget offer, although not yet formalised, it was understood to include pay increases for social care workers, Scottish Government allocations, and an additional savings target for social care within the broader financial challenge.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed to submit the draft Financial Plan to Scottish Government by 16 March with a cover letter explaining that the draft plan remained a work in progress and a further timeline for the final plan would be submitted in due course.

The **RESOURCES & PERFROMANCE COMMITTEE** agreed to form a shortlife working group "Strategic Budget Review Group" with a Non Executive Chair and input from partnership. The group would look at the longer term in regard to how decisions around budget setting are taken to move into the longer term territory ie consideration of zero based budgeting, programme budgeting, population health factors, etc.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed to add "financial plan" to the Private Board meeting agenda for a further discussion.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed the draft initial offer to the IJB could be issued.

12. Any Other Business

The **RESOURCES & PERFORMANCE COMMITTEE** noted there were no further items notified for discussion.

13. Date and Time of Next Meeting

13.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 7 May 2026 at 9.00am via MS Teams

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Audit & Risk Committee Minutes**
Responsible Executive/Non-Executive:	**A Bone, Director of Finance**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Audit & Risk Committee with the Board.

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 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.

- Audit & Risk Committee 23 March 2026

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Audit & Risk Committee minutes 15.12.25

Minutes of a Meeting of **Borders NHS Board Audit & Risk Committee** held on Monday, 15th December 2025 @ 10 a.m. via MS Teams.

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

In Attendance: A Bone, Director of Finance
J Boyd, Director, Audit Scotland (Left meeting at 12.05 p.m.)
S Cadden, Risk Advisory Manager (BDO) (Item 6.3)
G Clinkscale, Director of Urgent Care, Community Services and Mental Health (Left meeting at 10.45 a.m.)
M Clubb, Director of Pharmacy (Item 6.2)
S Errington, Head of Planning & Performance (Item 10.1)
B Everitt, Personal Assistant to Director of Finance (Minutes)
S Harkness, Senior Finance Manager
S Harold, Senior Audit Manager, Audit Scotland
L Jones, Director of Quality Improvement
G MacLeod, Risk Advisory Services Manager, BDO
C Robertson, Director and Head of Risk Advisory Services (Scotland), BDO
S Thomson, Information Governance & Cyber Assurance Manager/ Data Protection Officer

1. **Introduction, Apologies and Welcome**

James Ayling welcomed those present to the meeting.

James advised that Karen Hamilton had been unable to attend her last Committee meeting due to a diary clash and took the opportunity, on behalf of the Committee, to thank Karen for her contribution over the years and wished her well on her retirement.

Apologies were received from L O'Leary, Non Executive Director, D Parker, Non Executive Director, K Hamilton, Chair, P Moore, Chief Executive and S Swan, Deputy Director of Finance.

James confirmed that today's meeting was quorate.

2. **Declaration of Interest**

There were no declarations of interest.

3. **Minutes of Previous Meetings – 22nd September 2025**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker
Andrew Bone referred to the last action regarding the Contracts Management Arrangements recommendations, and in particular to checking with the officers involved if there were any record of the discussions which had taken place. Andrew advised that he planned to issue an update, which will include this information, in due course.

The Committee noted the action tracker.

Contracts Update
Andrew Bone referred to the action on the tracker for an update to be provided on all contracts being managed across the organisation to give a position statement on these. Andrew advised that this was still a work in progress and he was following up on information received so unfortunately was unable to provide this today. However, by way of a high level update meantime Andrew advised that 75% of non pay expenditure which is contracted is done so with other NHS bodies / private healthcare through the commissioning process. Just over 20% related to contract awards via Procurement, either at local or national level. An estimated 2% was for non-contract spend which was currently being reviewed and a further 1% issued on tender waivers. In regard to the 20% spend it was noted that the contract value accounted for around £30m of expenditure awarded in contracts for items outwith the NHS supply chain, e.g. equipment. Andrew advised that they were currently working through the renewal dates for contracts where ownership primarily lay within Estates, IM&T and Procurement. It was noted that work was ongoing to put in place a more controlled process and although there were weaknesses in the current process there did not appear to be anything like the scale of the recent LIMS contract.

Andrew advised that a written report would be issued when work was concluded and there was more clarity around the areas being followed up on.

James Ayling enquired if the work being undertaken would identify the staff who required to be trained in this area. Andrew confirmed that it would.

Lynne Livesey asked if action could be taken in the meantime to prevent anything being taken forward outwith the regulated system to worsen the situation in advance of staff training taking place. Andrew advised that he planned to issue a comms across the organisation in due course detailing the process that is being undertaken and laying out the interim position.

The Committee confirmed it had received a moderate level of assurance.

The Committee noted the update.

5. **Risk Management**

5.1 *Operational Risk Management Bi-Annual Report*
Laura Jones spoke to this item. Laura explained that when InPhase was launched all training was renewed and reset at zero and highlighted that the compliance rates detailed on page 14 noted a 74% uptake. In regard to training for managers, which was only launched in October, compliance rates were as expected still quite low but Laura anticipated seeing good progress within the next

report. Laura also referred to the section on KPIs and flagged that the one for risks being taken through the appropriate risk appetite process should be noted as amber rather than green. Laura went on to update that when the report was circulated there were still 11 risks which hadn't been through the appetite process, however 5 of these were scheduled to be considered over the next month with the remainder being considered prior to the end of the financial year.

It was also noted that targeted work had been undertaken around risk improvement plans and this was detailed on page 18 where Laura was pleased to report that the assurance level had improved as a result of this with only 2 areas still reporting limited assurance, namely Corporate Services and Unscheduled Care.

James Ayling stated that he was pleased to see an increase in stakeholder input and went on to highlight reference to the statement that £480k had been agreed to be funded from the risk fund this financial year to support the reduction of 4 very high risks and 2 high risks. James asked for an update on the governance around this as he was aware that anything above £250k required Board approval. Andrew Bone advised that this was a delegated reserve and any decision made by the Board Executive Team or Operational Planning Group within the risk fund process are covered under this delegation. Andrew added that this fund is a one term commitment which replenishes each year and has no recurring commitments made against it.

Lynne Livesey referred to the Cardiology Consultant risk assessment which had fallen outwith the risk fund process and had not followed the approved governance structure. Owing to this Lynne did not feel that this fell within the delegated authority given by the Board as the correct process had not been followed.

Laura felt this may have been an misinterpretation of the language used and went on to provide the background around the situation where this had arisen due to the urgency of the risk regarding the staffing situation.

Lynne also highlighted the number of very high risks outwith the review date as she felt that this was particularly high. Laura advised that at the point of the report being produced there were 10 out of the 39 risks outwith the review date, however since the report had been circulated there only remained 5 outstanding which would be escalated through the appropriate channels.

The Committee confirmed it had received a moderate level of assurance.

The Committee noted the report.

6. **<u>Internal Audit 2024/25</u>**

6.1 *Internal Audit Plan Update Report*
Gemma MacLeod spoke to this report which provided a summary on the delivery of the 2025/26 Internal Audit plan. Gemma confirmed that she was comfortable with progress on the plan and went over the timelines for the remaining audits.

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

The Committee noted the report.

6.2 *Internal Audit Report – Medicines Governance & Prescribing*
Gemma MacLeod introduced this report which had an overall rating of limited assurance for design and limited assurance for effectiveness. The finding ratings were noted as 3 high and 3 medium. Gemma explained that the three high risk areas looked at had been flagged by managers, namely paper based prescribing, osteoporosis prescribing and polypharmacy reviews.

Gemma went on to take the Committee through the high rated findings, namely challenges with the paper based prescribing, where through the course of the audit several limitations and risks had been found with the approach used. It was noted that a business case was being developed for electronic prescribing and recommendations had been made in line with this.

The second high risk finding related to perceived cultural issues flagged and medication issues reporting and inconsistent completion of training. It was noted that management suspected there may have been an under reporting of issues due to time constraints and potential fear of blame. It was noted that there was a Medication Governance & Safety Group who met on a quarterly basis, however there was limited evidence of follow-up actions from audits. Prescriber training was also irregular with no firm schedule set out in key policy documents.

The remaining high risk finding related to the lack of an electronic system so there was lack of oversight as to whether the 5 yearly reviews for osteoporosis medications were taking place as per the guidance. Due to this, sample testing could not be undertaken to ascertain if these were taking place as required.

Gemma went on to take the Committee through the medium rated findings relating to the guidance in place for osteoporosis treatment and highlighted that the guidance found on the Intranet was outdated. It was noted that a new SOP had been drafted but was yet to be finalised. This had been compared to the national guidance and discrepancies had been found. Gemma raised the question as to whether there was a need for local guidance or whether the national guidance should be followed.

The second medium rated finding noted that polypharmacy reviews were required to be undertaken manually in the secondary care setting due to the lack of an electronic system as previously highlighted.

The third medium rated finding highlighted that at the time of the audit there were issues with Pharmacy accessing the EMIS PCS system as part of polypharmacy reviews and this required GPs to grant access. Gemma advised that management have since confirmed that this issue has been resolved.

Malcom Clubb felt that it had been of great benefit to get this documented through the audit and none of the risks identified within the report had come as a surprise. Malcolm confirmed that he had supplied the management responses which had been done in isolation of Dr McCallum, the Executive Director for this area. Malcolm went on to list the issues incurred by the Board not having HEPMA, the electronic prescribing system, in place which had many benefits and would assist with many of the findings arising from the audit. It was noted that the report and an action plan would be taken to the Clinical Governance Committee in January.

Laura Jones referred to reference within the report to InPhase reporting, and as the Executive Director responsible, did not recognise the comments made nor could recall having a conversation around this and would like to get a better understanding. Gemma advised that the comments around a lack of reporting had been raised within interviews and that she would pick up outwith the meeting.

Andrew Bone highlighted that the overarching risk was not having an electronic prescribing system in place which would require a business case to be presented to the Board and confirmed this would be coming forward in due course.

Lynne Livesey noted the high combined risks and enquired what could be done in the interim to help improve the level of risk faced by the organisation. Lynne also referred to the issues around reporting on InPhase and staff fearing blame for what was reported and stressed that staff should be comfortable to report things in the appropriate manner with no fear of repercussions.

Laura appreciated that the lack of an electronic prescribing system had been flagged to the Board for some time and was aware NHS Borders was the last Board in Scotland to move to this due to financial constraints.

James Ayling referred to the overall governance in place and noted that there was no specific governance group for polypharmacy. Malcom advised that this could be put in place, however it would mean resources being tied up in meetings rather than working with patients so would not be efficient in terms of gains. Malcolm highlighted there may be other options to address this and would also be happy to have a discussion, as per the recommendation, about setting up a Programme Board. Malcolm added that there had been discussions with the regional TrakCare Group around the possibility of creating a template on TrakCare to capture the number of reviews undertaken to be able to give assurance around this in future.

James noted that there was no central record held for polypharmacy training as this was recorded on an individual's TURAS account. Malcolm explained that work was progressing around this and will involve the member of staff undertaking training on Turas and adding the certificate when completed onto the Learnpro system so training portfolios would then all be captured within Learnpro.

James referred to previous discussions by the Board where the minutes stated that capital funding had been identified to support the implementation of HEPMA. Andrew confirmed that this had been included as an early estimate in the capital plan 3 years ago but had subsequently been superseded and there was currently no funds earmarked for this. Andrew highlighted that the capital element would be relatively minor and expected the project support costs to be the largest

element. Andrew added that software issues within existing pharmacy systems at that time had also prevented implementation.

James noted that the implementation date for HEPMA being operational was 2030 and as this was a number of years away asked if anything could be done in the interim to further mitigate the risks. Malcolm explained the timescales around the implementation process to having the system fully operational on wards and felt that the timescale provided was realistic. Andrew Bone added that when the business case comes forward the Board can support as a priority and suggested it may be more appropriate to track the approval of the business case for HEPMA rather than the implementation itself.

Lynne Livesey understood the challenges described but as NHS Borders was an outlier queried if the business case could be expedited, i.e. asking for information from other Boards who have already implemented this or more resources being made available, as a year seemed an awful long time even taking into account the complexities involved.

Andrew advised that the issue was around the prioritisation of resources and felt that the strategic case should be straight forward, however the financial and economic cases needed to be reviewed to ascertain how this can be afforded. Andrew also stressed that a key element in this was the availability of capital resource which was outwith the Board's control, noting in order to get capital resource prioritised for this something else in the capital plan would have to be de-prioritised or to seek additional capital funding from Scottish Government.

James noted his concern regarding the comments around prescriptions for controlled drugs and enquired if procedures and controls in this area were appropriate. Malcolm described the procedure used and advised that guidance on how to write a controlled drug prescription had been circulated to all relevant areas.

James also enquired why osteoporosis prescribing had been selected for review and asked if there were any other areas where periodic prescription reviews were not taking place. Malcolm advised that this had been picked as there were concerns around anomalies in the information received for this area which relied on Primary Care colleagues and osteoporosis clinicians to recognise when a patient was due for a 5 yearly review. Malcolm went on to detail the current process where it was noted that the date when a 5 year review was due is manually added to each monthly prescription to alert when this requires to be undertaken. Malcolm highlighted that it was difficult to have any influence in this area due to it predominantly being Primary Care's remit.

Regarding any other areas being in a similar position, Malcolm confirmed that as far as he was aware patients who were on multiple medications should, in the norm, be receiving "birthday month reviews".

James enquired if Internal Audit would be able to benchmark against other Boards in regard to the medication errors. Gemma advised that they did not hold any data on errors at the present time but had asked a colleague in England to review the report and the key issue flagged by them was the absence of HEPMA.

Lynne stated that she did not feel that the Committee had received the necessary assurances owing to the extremely high risks identified within the report.

Laura Jones agreed to provide a verbal update on discussions by the Clinical Governance Committee at future meetings.

The Committee confirmed it had received a limited level of assurance for systems and processes and limited assurance for outcomes.

The Committee noted the report which would have oversight by the Clinical Governance Committee.

6.3 *BDO External Support – Contract Management Report*

Sophie Cadden provided an overview on the work undertaken to date in regard to supporting the recommendations arising from the contract management audit. It was noted that recent focus had been on ensuring the correct project management tools and governance were in place. Sophie advised that she had been working closely with the Head of Procurement to gain an understanding of current processes and the areas for improvement as well as having initial discussions with Estates. Time had also been spent looking at the Agility system and trying to understand the part it plays in the process. Discussions had also been scheduled with IT colleagues but these had been delayed until January, however this was not expected to have an impact on the timeline. A steering group had also been formed with key contacts who met on a regular basis.

Sophie referred to the high level timeline which had been circulated with the papers for the Committee's information.

Sophie advised that the Head of Procurement had broken down supplier spend greater than £50k over the last year to mitigate risks with suppliers who currently didn't have a contract in place. It was noted that 3% of these did not have a formal agreement in place and amounted to £4.3m. To manage this situation a temporary instruction would be issued to any new supplier spend with a non contracted supplier to gain control over the unmanaged spend until the new processes were put in place. It was also noted that a non contracted spend register would be created.

James Ayling was reassured that this was being looked at in depth and would like to receive an update report at the next meeting.

The Committee confirmed it had received a significant level of assurance for systems and processes.

The Committee noted the update.

7. <u>Governance & Assurance</u>

7.1 *Information Governance – Mid Year Update*

Susie Thomson spoke to this report which provided an update on the key areas of work undertaken over the previous 6 months. Susie highlighted that it had been a challenging period with an increased demand to support digital programmes of work across the organisation. Susie advised that one of the

Information Governance team, out of a total of 3, was due to retire early in the new year and flagged that there was a high risk of not being able to recruit to this post.

Susie highlighted that preliminary planning work for the implementation of the system replacing OneTrust, the GDPR compliance tool, was also being undertaken. Susie advised that the new system would help drive efficiencies and provided examples of these.

Although Freedom of Information was not under the remit of Information Governance, Susie advised that they were facing significant demands with a 20% increase on last year's activity for the same period reported. It was noted that should the response rate go below the current 75% there was a risk of intervention.

Susie advised that Health Records Services are experiencing significant challenges, both in terms of resources and space requirements, to manage the increase in patient records. It was noted that business continuity measures to sustain the core service have been put in place and discussions are ongoing around how to manage this risk. Susie highlighted that NHS Borders is the only Board in Scotland not to have an electronic system in place.

In regard to cyber security Susie explained that they were a year into the programme of work but were still struggling on how to test some Business Continuity Plans (BCP). It was noted that the team continue to link closely with the Business Continuity & Resilience Team around this and when a department's BCP is finalised it will be tested by running a desktop resilience test which will include input from cyber governance.

James Ayling noted that mandatory cyber security training was recorded as 68% which was a reduction for the same period last year. James enquired if there was anything which could be done to help improve this. Susie explained that there was an issue with Learnpro which may have impacted on the statistics and this was being addressed with the developers. In addition, it was planned to send targeted emails to line managers who had low compliance levels as well as issuing a comms across the organisation on the Learnpro issue which would hopefully see an increase in completion rates thereafter.

Lynne Livesey commented on the high risk to the organisation with still having a paper based system which increased the risk of data governance breaches and this was another example of the Board being an outlier across Scotland. Lynne hoped to see this prioritised going forward.

James highlighted the issues experienced around quoracy at the Information Governance Committee meetings. Susie advised that the meeting the previous week had once again not been quorate and they had discussed how this could be improved going forward as it was felt these meetings were not being prioritised in diaries.

The Committee confirmed it had received a moderate level of assurance.

The Committee noted the report.

7.2 *Audit Follow Up Report*

Gemma MacLeod spoke to this item. Gemma provided background on the approach to the follow up report and highlighted the conclusion which noted a slight improvement of actions being fully implemented from 7% to 11%, albeit still a very low rate overall.

James Ayling enquired what would be the best way to monitor progress going forward. Gemma explained that they would continue with the same format and raise anything for the Committee's attention within the conclusion section. Gemma recommended that the Committee pay particular attention to actions rated as high significance.

Andrew Bone advised that the report is also reviewed by the Board Executive Team to see if anything can be done to address issues and give executive oversight.

The Committee confirmed it had received a moderate level of assurance for systems and processes in place and limited assurance around the outcomes achieved.

The Committee noted the report.

7.3 *Debtors Write Off Report*

Andrew Bone spoke to this item which was a routine report received by the Committee, however given the scale of write-off being proposed he felt further discussion was required. Andrew referred to the table on page 4 which proposed £600k being written off. It was noted that over half of this related to debt over 5 years old and a significant write-off for a secondment from NHS England which the Board had been unable to resolve to date. Andrew assured that processes were in place as per agreed governance arrangements, however this debt had been carried for an exceedingly long period and all debt recovery avenues had been exhausted. Andrew advised that he was still keen to pursue the debt with NHS England. It was noted that there was an expectation to bring a similar recommendation to the Committee prior to the year-end to avoid carrying long-term financial debt unless something was under dispute or awaiting resolution.

Andrew highlighted that he was empowered to approve the write-off but was not comfortable to do so without first discussing with the Committee and went over the debt being recommended for write-off.

The Committee discussed the proposed write-offs and agreed with the recommendations with exception of the one with NHS England which they agreed should continue to be pursued.

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

The Committee noted the report and agreed to the proposed write-offs with exception to the one with NHS England which should continue to be pursued.

7.4 *Audit & Risk Committee Terms of Reference & Workplan*
Andrew Bone spoke to this item and advised that there were no changes proposed to the Terms of Reference and the Workplan.

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

The Committee recommended the Terms of Reference go forward to the Board for formal approval as part of the next refresh of the Code of Corporate Governance.

The Committee approved the annual workplan.

8. External Audit

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

James Ayling asked that the NHS in 2025 report be added to the agenda for the March meeting.

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

The Committee noted the report.

9. Fraud & Payment Verification

9.1 *Countering Fraud Operational Group Update*
Andrew Bone provided an update where it was noted that the new Deputy Director of Finance, who was due to take up post in January, would be assuming the role of the Fraud Liaison Officer and taking forward the fraud agenda, which included support to the Countering Fraud Operational Group.

Andrew assured that there is good engagement with the directorates who have the potential for fraudulent activity.

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

The Committee noted the update.

9.2 *NFI Update*
Andrew Bone spoke to this item where it was noted that the Board continues to participate and all matches had been closed with the exception of 2 which were currently being reviewed.

James Ayling noted concern around the £18k of duplicate payments and hoped that this was not due to a systemic issue.

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

The Committee noted the report.

9.3 *Fraud Allegations*
Andrew Bone provided an update on fraud allegations where he reported that currently there were 5 fraud allegation cases and went on to provide an update on these. It was noted that 2 of these had been carried forward from previous years plus 3 new referrals during 2025/26.

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

The Committee noted the update.

10. **Integration Joint Board**

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

10.1 *IJB Directions Tracker*
Steph Errington spoke to this report which was a standing item and provided updates on existing and new directions. It was noted that there had been no new directions issued from the IJB this financial year to date. Steph highlighted the appendix which detailed updates to those issued the previous financial year.

James Ayling referred to the comment at the last meeting regarding the vacant Chief Officer post and asked if this was still the case. Steph confirmed that it was.

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

The Committee noted the IJB Directions Tracker.

11. **Any Other Competent Business**

None.

12. **Date of Next Meeting**

Monday, 23rd March 2026 @ 10 a.m. via MS Teams.

BE
23.12.25

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Finance Report – February 2026**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Senior Finance Manager** **Paul McMenamin, Finance Business Partner** **Maryam Khan, 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 NHS Scotland 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, 17th March 2026
- BET – circulated for awareness, week ending 27/03/26

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 2026

FINANCE REPORT FOR THE PERIOD TO THE END OF FEBRUARY 2026

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 2026 and the impact on year-end forecast.

2 Recommendations

2.1 Committee Members are asked to:

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

YTD Performance	£8.79m overspend
Outturn Forecast at current run rate	£9.59m overspend
Projected Variance against Financial Plan (current run rate)	£3.21m improvement
Actual Savings Delivery (current year effect)	£8.73m (actioned)
Projected gap to Forecast	Best Case £9.59m (Trend) Worst Case £10.0m (Forecast)

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 2026.

Table 1 – Key Financial Indicators

	Financial Plan £m	Month 11 £m
Summary		
Year to Date (forecast/actual)	(11.73)	(8.79)
Core Operational	(6.71)	(4.66)
Board Reserves & Flexibility	8.51	7.80
Savings	(14.60)	(11.93)
Average Monthly Run Rate	(1.07)	(0.80)
Outturn Forecast (pro-rata)	(12.80)	(9.59)
Outturn Target (Scottish Government)	(10.00)	(10.00)
Updated Forecast Q3	-	(10.00)
Savings		
Full Target	(19.66)	(19.66)
In year target	(12.15)	(12.15)
Forecast Delivery	12.15	12.15
Recurring Schemes		
Implemented		5.68
Planned/Mandated Schemes	6.44	2.41
In Development / At Risk	2.68	1.02
Non Recurring Schemes		
Implemented	-	3.05

	Financial Plan	Month 11
Planned/Mandated Schemes	2.19	0.05
In Development / At Risk	-	-
Cost Avoidance Measures		
YTD Achieved		0.20
Forecast at Current Run Rate	0.85	0.22
Slippage at Risk	-	0.63
Brokerage Memo		
Accumulated Brokerage Mar-25	48.83	48.83

4 Summary Financial Performance

4.1 The board's financial performance as at 28th February 2026 is an overspend of £8.79m. This position is summarised in Table 2, below.

Table 2 – Financial Performance for eleven months to end February 2026

	Opening Annual Budget	Revised Annual Budget	YTD Budget	YTD Actual	YTD Variance	Forecast Outturn as at Q3
	£m	£m	£m	£m	£m	£m
Revenue Income	350.15	398.39	363.51	364.09	0.59	0.25
Revenue Expenditure	350.15	398.39	344.46	353.84	(9.38)	(10.25)
Surplus/(Deficit) for Period	**-**	**-**	**(19.05)**	**(10.26)**	**(8.79)**	**(10.00)**

4.2 Operational Performance (year to date)

4.2.1 Overall financial performance at Month 11 is £8.79m overspent. This position is driven by expenditure overspend against budget, with a slight over-recovery of income netted against this position.

4.2.2 Excluding savings, the year to date operational overspend is £1.48m. This is driven by operational pressures as described in section 5.2.

4.2.3 Within expenditure budgets there is £11.93m unmet savings year to date, as reported against Business Unit targets.

4.2.4 This includes £9.72m non-delivery (year to date) as projected within the 2025/26 financial plan, representing the level of savings target deferred to year 3 of the plan as set at April 2024. This element is included within the financial plan forecast deficit.

4.2.5 The unplanned element of savings non-delivery is therefore £2.27m[1] (year to date) with a full year effect of £2.47m. This represents savings not yet delivered (£2.35m) against plan, and a further £0.12m of savings not identified against target. This is discussed further in section 6.8 of this report.

4.2.6 Offsetting the above pressures is £7.80m (£8.51m full year) in respect of additional non-recurrent measures, comprising Scottish Government support (£5.51m) and release of corporate flexibility to savings (£3m).

[1] £11.93m year to date undelivered, less £9.66m 'planned' non-delivery (year 3 target), equals £2.27m year to date unachieved against in year target.

4.2.7 A breakdown of the boards income and expenditure has been included in Appendix 1. This represents the information reported to Scottish Government via the Financial Performance Returns each month and shows the boards income and expenditure against several key headings. This data is presented by Business Units in Section 5 of this report.

4.2.8 Several key trend areas have been included in Appendix 2, which again represent data reported to Scottish Government. These key trends show the monthly spend against some of the highest cost areas including Agency spend to show the trend over the last 17 months.

4.3 Savings Delivery

4.3.1 The financial plan assumes delivery of £9.11m recurring savings during 2025/26 which would result in a residual balance of unmet savings to be carried forward of £10.60m.

4.3.2 If savings were delivered on a pro-rata basis (i.e. equally over the twelve months) then this would be expected to result in a shortfall of £9.72m after eleven months. The year-to-date position of £11.93m unmet savings highlights the extent to which savings are either not identified or are phased to deliver in later periods.

4.4 As previously advised, there are mitigations in place to offset non-delivery of savings in 2025/26. As at M11 additional non-recurrent savings have been transacted and are included in the amended year end forecast. Nonetheless the continued slippage against plan presents a significant risk to the underlying deficit and opening financial position at March 2026.

4.5 As at M11, the recurring savings delivered to date have a current year effect of £4.80m. This is lower than the savings delivered at this point during 2024/25 and focus on delivering recurring savings needs to remain constant to ensure the Board meets its Financial Plan targets. This situation is discussed further in Section 6.

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 2026.

Table 3 – Income by Category, year to date February 2025/26

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m	Forecast Outturn as at Q3 £m
Income Analysis						
Revenue Resource Limit	329.25	366.18	335.67	335.67	(0.00)	-
Family Health Services	10.24	19.06	17.47	17.47	0.00	-
External Healthcare Purchasers	4.55	4.65	4.25	4.27	0.03	0.06
Other Income	6.11	8.50	6.12	6.68	0.56	0.19
Total Income	**350.15**	**398.39**	**363.51**	**364.09**	**0.59**	**0.25**

5.1.2 There is an over recovery on other income which is linked to income received in relation to Resident Doctors and is linked to timing of income.

5.1.3 There is a slight over recovery on External Healthcare Purchasers. This over recovery is likely to continue to year end and is largely driven by revised estimates for Scottish SLA activity, which have been adjusted using a rolling average approach. Emergency care income from Scottish UNPACs and OATS has also increased due to higher-than-expected costs per patient, although activity volumes remain stable. These areas are inherently variable and may fluctuate with seasonal trends.

5.2 Operational performance by business unit

5.2.1 Table 4 describes the financial performance by business unit in February 2026.

Table 4 – Operational performance by business unit, February 2026

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m	Forecast Outturn as at Q2 £m
Operational Budgets - Business Units						
Acute Services	84.73	101.84	92.72	91.51	1.21	(1.58)
Acute Services - Savings Target	(4.08)	(3.11)	(2.85)	-	(2.85)	(3.54)
TOTAL Acute Services	**80.65**	**98.73**	**89.87**	**91.51**	**(1.64)**	**(5.12)**
Set Aside Budgets	34.52	38.83	35.59	38.71	(3.11)	(5.31)
Set Aside Savings	(3.83)	(2.01)	(1.85)	-	(1.85)	(2.49)
TOTAL Set Aside budgets	**30.69**	**36.82**	**33.75**	**38.71**	**(4.96)**	**(7.80)**
IJB Delegated Functions	121.69	170.75	147.85	146.74	1.10	0.26
IJB – Savings	(5.00)	(3.28)	(3.01)	-	(3.01)	(4.06)
TOTAL IJB Delegated	**116.69**	**167.47**	**144.84**	**146.74**	**(1.91)**	**(3.81)**
Corporate Directorates	23.41	25.38	23.12	23.66	(0.54)	1.70
Corporate Directorates Savings	(1.73)	(0.74)	(0.68)	-	(0.68)	(1.65)
TOTAL Corporate Services	**21.68**	**24.64**	**22.45**	**23.66**	**(1.22)**	**0.05**
Estates & Facilities	24.75	25.72	23.58	23.36	0.22	0.37
Estates & Facilities Savings	(2.10)	(1.43)	(1.31)	-	(1.31)	(1.97)
TOTAL Estates & Facilities	**22.65**	**24.28**	**22.27**	**23.36**	**(1.09)**	**(1.60)**
External Healthcare Providers	36.61	38.38	35.18	36.61	(1.43)	(1.06)
External Healthcare Savings	(2.75)	(2.39)	(2.19)	-	(2.19)	(2.33)
TOTAL External Healthcare	**33.86**	**35.99**	**32.99**	**36.61**	**(3.62)**	**(3.39)**
Board Wide						
Depreciation	5.87	5.87	5.38	5.38	0.00	-
Year-end Adjustments	1.28	(11.55)	(11.65)	(12.13)	0.48	(0.15)
Planned expenditure yet to be allocated	32.00	7.67	1.87	-	1.87	14.67
Central Unallocated Savings Target	-	(0.05)	(0.05)	-	(0.05)	(0.05)
Central Unallocated NR Savings Achieved	3.00	3.00	2.75	-	2.75	3.00
Board Flexibility	1.78	5.51	-	-	-	(6.05)
Total Expenditure	**350.15**	**398.39**	**344.46**	**353.84**	**(9.38)**	**(10.25)**

5.2.2 **Acute[2] Overall**.

[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.

The position is £6.60m overspent with £1.90m relating to operational overspend and £4.70m relates to non-delivery of the remaining element of the three-year saving targets of £10.3m.

Savings Summary: The £10.3m recurring three-year target set in 24/25 has been reduced to £7.5m due to the savings achievement made by the Acute Board in 2024/25. The Acute Board has a savings plan for £1m and are currently working on the feasibility of all savings commitments. The proportion of saving retracted in 25/26 is a minimum of 3% or £3.1m recurring cash releasing savings. The focus is now on 26/27 and long-term transformative change in order to deliver recurring savings for the full 3 year target.

5.2.3 **Acute Services (excluding Set Aside)** is reporting a YTD overspend of £1.64m, of which £1.21m relates to operations and £2.85m related to savings.

Operational Summary: The main drivers of cost pressures remain in line with previous periods. Use of agency to cover medical workforce gaps across a number of services including Paediatrics, Obstetrics and Gynaecology and General Medicine Agency staff continue to be used to cover out of hours services across both medical and nursing workforce. There remains significant cost pressure across supplies and instruments, although inflationary uplift has been addressed through additional budget allocation in M10. Diabetes equipment and consumables continue to exceed available budget; this is consistent with demand demonstrated across NHS Scotland. Drug pressures are partially offset by release of non-recurrent budget from reserves in M10 however growth remains above funded levels. Contributing factors also include ongoing clinical demand, staffing constraints, and the use of external reporting support in radiology.

5.2.4 **Set Aside.** The set aside budget is overall, £4.96m overspent, at the end of February 26. This overspend is broken down into £3.11m operational overspend and £1.85m related to savings.
The unmet savings reported in the position relate to eleven twelfths of the saving required to be achieved during 25/26 and 26/27. The Acute Board has plans retracted to achieve the minimum requirement for 25/26 of 3% recurring and this overspend decreases as plans are completed.

5.2.5 Overspend continues across unscheduled care, primarily driven by the sustained operation of additional surge beds and pressures in medical staffing, including the use of agency cover for sickness absence. While the drugs budget has been funded to match prior year expenditure, specific areas—such as dermatology and haematology—remain as emerging and consistent cost pressures.

5.2.6 **IJB Delegated.** Excluding non-delivery of savings, the HSCP functions delegated to the IJB are reporting a net underspend on core budgets of £1.10m. Within Mental Health (net £0.060m overspend excluding savings), medical agency use (locums) continues to be an increasing pressure (£1.031m), together with an unfunded Physician Associate (£0.066m), partially offset by savings within the MH Drugs budget of £0.220m. Nursing pay budgets are reporting underspends of £0.397m after taking into account bank / agency costs. Psychology, as a result of the Waiting List Initiative is now reporting a small overspend in pay (£0.054m), together with a shortfall in Income (£0.026m), primarily attributable to NES funding. Admin continues to report pay underspends of £0.185m due to ongoing vacancies. There continues

to be other miscellaneous underspends across the Business Unit of primarily due to slippage in the use of MH Outcomes Framework funding of £0.240m that has now been redirected to Supplies and other miscellaneous underspends amounting to £0.075m.

5.2.7 The largest area of financial pressure across Delegated Functions again relates to Learning Disability (£1.260m) attributable to out-of-area placements (£1.310m) at the end of the M11 offset by pay vacancies of £0.050m.

5.2.8 Primary Care Prescribing is reporting an overspend position of (£0.190m) at M11. A higher than average trend in the volume of items dispensed (7.5% c/f 2023/24) continues, although the average cost per item has been again lower during the second quarter of the financial year, and volumes, whilst variable, remain lower than previously forecast, resulting in the current underspend position following £1.480m of investment earlier in the financial year.

5.2.9 Within Primary and Community Services there is a net underspend at M11 of £2.62m. Dental Pay savings from vacancies of £0.541m as well as underspends in Supplies budgets (£0.232m) are a key driver of this, partially offset by a shortfall in income of £0.122m due to reduced activity levels.

5.2.10 Community Hospitals are continuing to report underspends within pay linked to vacancies of £0.526m as well as small levels of savings within supplies of £0.040m.

5.2.11 Community Nursing Pay budgets continue to report significant underspends as a result of vacancies of £0.674m. These however are significantly offset by Supplies overspends primarily attributable to Dressings (£0.272m).

5.2.12 Vaccination and Immunisation continue to report an overspend mainly driven by Shingles and Flu vaccine costs (£0.315m).

5.2.13 There are also ongoing pressures as a result of the closure of the Knoll (£0.155m) but these are more than offset by current underspends across P&CS HQ and Other of £0.991m.

5.2.14 Allied Health Professional Services continue to report an underspend position excluding savings of £0.471m, primarily relating to vacancies within pays.

5.2.15 **Corporate Directorates** are reporting a net over spend of £0.54m on core budgets. The underspend observed in previous months continues, primarily across departments such as Workforce, Pharmacy, Planning and Performance, and Finance. These areas are either undergoing workforce reviews or have completed them but are still experiencing underspends due to challenges in recruiting to the agreed staffing models. As a result, the savings being realised are non-recurring in nature.

5.2.16 **Estates & Facilities** are reporting an operational underspend of £0.22m. The underspend in Estates & Facilities is primarily due to staffing vacancies. Within Estates, workload pressures remain, and recruitment to key posts is necessary to address these. As vacancies are filled, the underspend is expected to reduce and should therefore be considered non-recurring. In Facilities, staffing levels are aligned to nationally agreed cleaning standards, and any sustained underspend would only be recurring if the Board were to revise its commitment to those standards.

This underspend is offset by overspends in supplies within facilities, specifically Patient Transport which continues to face cost pressures due to an increasing number of patients requiring travel to Edinburgh for cancer treatment. This issue was highlighted during 2024/25 and remains ongoing. A piece of work will be commissioning looking at transport as a whole which will seek long term solutions.

5.2.17 **External Healthcare Providers** Excluding savings there is an over-spend of £1.43m. This position is driven by cost of individual high cost placements at private healthcare facilities (predominantly Learning disabilities patients with complex needs) and expenditure growth on NHS cross boundary flows; cost of NHS Lothian SLA has increased in year, including cost inflation and increase volume of emergency activity, including within neonatal services.

6 Savings Delivery

6.1 The savings targets set within the Financial Plan for 2024/25 are £9.12m recurring (3%) and £3.04m non-recurring (1%).

6.2 The FIP Board has agreed that targets set at individual business unit level should continue to be monitored against the three year target set in 2024/25. This means that there is a difference between the target set within the financial plan and the operational targets included within individual business unit budgets.

6.3 This issue is addressed by creation of an unallocated ‘organisation wide’ target which is expected to be managed through identification of workstream schemes not included within business unit plans. This approach has been viewed as preferable to minimise disruption to local plans and to ensure that there is consistency of approach across the three year period to March 2027.

6.4 Given the scale of risk inherent in this assumption, provision was made at £3.04m (1%) within the plan; in effect, this reduces the forecast delivery in year to 3% overall (£9.12m). This forecast remains above the level of savings identified within the plan.

6.5 It should be noted that Scottish Government has set an expectation that all NHS Boards deliver a minimum of 3% recurring and that the position outlined above is consistent with this approach. The additional non-recurrent target set out above is in line with the three year local target (10%) set in 2024/25 and is required in order to achieve the trajectory set out over the medium term financial plan.

6.6 Actual Savings Delivery

6.6.1 Table 5 below shows actual level of savings achieved to date, including amounts expected to be delivered to March 2026 in respect of schemes implemented in January 2026.

Table 5 – Current year savings achieved as at February 2026

	Savings Target (inc. NR) £m	Recurring Savings Achieved £m	Non Recurring Savings Achieved £m	Total Achieved £m	Unmet Savings (current year) £m
Acute Services	(2.50)	0.08	0.00	0.08	(2.43)
Set Aside	(1.67)	2.42	0.00	2.42	0.76
IJB Directed Services	(2.26)	1.32	0.00	1.32	(0.94)
Prescribing	(1.02)	0.54	0.00	0.54	(0.49)
Corporate Directorates	(1.07)	0.29	0.03	0.32	(0.75)
Estates & Facilities	(0.90)	0.66	0.00	0.66	(0.24)
External Healthcare Providers	(1.68)	0.37	0.03	0.39	(1.29)
Central Unallocated Target	(1.05)		3.00	3.00	1.95
Total	**(12.16)**	**5.68**	**3.05**	**8.73**	**(3.43)**

6.6.2 Against the 2025/26 target, £8.73m 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.

6.6.3 The balance of savings to be delivered in 2025/26 is £3.43m, with a minimum of £0.4m required to be delivered in order to meet the financial plan target (ref. para 6.4, above).

6.6.4 Section 6.8 sets out the value of schemes identified not yet enacted within the financial position. This indicates a forecast savings delivery of £7.14m (recurring) in 2025/26. Achievement of the forecast recurring savings would fall short of the level required as set out in the financial plan, and therefore focus should be given to ensure progress of those related schemes as well as continued identification of further schemes.

6.6.5 The level of unmet savings remaining against the three year target (10%) is £13.01m. This position will continue to be reported as a measure of progress towards delivery of the medium term plan. Continued slippage on recurring savings delivery presents a significant risk to the path to financial balance over the medium and long term.

6.7 Agency Use

6.7.1 The financial plan set an improvement target for cost avoidance of £0.85m through reduction of agency use. As highlighted in previous reports this target will not be met with agency use having increased significantly in current year.

6.7.2 Table 7 below reports the change in agency use against the same period for the previous year and projects forward to outturn position based on current trend.

Table 7 – Agency use by Staff Group

	Apr-Feb			Ave Monthly (FYE)		
	2024/25 £k	2025/26 £k	Movement (increase/ -decrease) £k	2024/25 £k	2025/26 £k	Movement (increase/ -decrease) £k
Medical	1625	3551	1927	151	323	172
Nursing	432	468	36	40	43	3
Other	439	500	62	130	45	-85
	2495	**4520**	**2025**	**321**	**411**	**90**

6.7.3 This increase in agency within Medical and Nursing over the first three quarters of this year is attributed to a requirement to sustain vulnerable services within key specialist posts (predominantly medical) and general workforce pressures arising from sickness absence and other factors.

6.7.4 Appendix 2 provides further information on trends in key costs, including agency staffing within context of overall pay expenditure.

6.8 Progress towards Implementation

6.8.1 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.

6.8.2 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.

6.8.3 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.

6.8.4 Table 8 summarises the recurrent plans identified by business units for 2025/26, as at end January. This is set against the 3% recurring target.

Table 8 – Recurring Plans 2025/26 by Business Unit

	Number of Schemes	3% Target £m	FYE £m	PYE £m
Acute	33	(3.13)	3.71	3.08
Commissioning	4	(1.26)	0.56	0.46
Corporate	13	(0.79)	0.41	0.40
Estates	8	(0.30)	0.53	0.53
Facilities	19	(0.38)	0.25	0.24
IJB - MH/LD	10	(0.61)	0.80	0.68
IJB - PACS	19	(1.08)	0.81	0.76
Primary Care Prescribing	35	(0.80)	1.54	0.99
	141	**(9.12)**	**8.59**	**7.15**

6.8.5 At M11 the forecast delivery has been further amended, and this now represents a delivery of £7.15m in year (£8.59m FYE). This represents an improvement on previous forecast, whilst remaining below target.

6.8.6 Table 9 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.

Table 9 – Recurring Plans 2025/26: Progress by Gateway

	FYE £m	PYE £m	Total Schemes
At planning stage	-	-	-
Gateway 1	1.30	1.11	44
Gateway 2	0.36	0.30	10
Gateway 3	1.20	0.93	14
Gateway 3 - Blue	5.74	4.80	73
Total Schemes	**8.59**	**7.15**	**141**

6.8.7 Approximately 31% of schemes remain at Gateway 1 and as highlighted throughout the current year, progress has been below the milestones set within the FIP programme. There has been some progress in past two months which has improved forecast against mid year however it remains the case that delivery in 2026-27 will fall below the 3% target set within the plan.

7 Scottish Government Oversight

7.1 The plan for 2025-26 was approved conditionally on the basis of further actions. Although these actions will not be delivered in full, the deficit support target (£10m) will be achieved and this will fulfil a key commitment within the plan.

7.2 Other actions required following approval of the 2025-26 plan included delivery of 3% recurrent savings (position described in section 6, above) and development of a medium term financial recovery plan.

7.3 This final action is considered superseded by the development of the Board's medium term financial plan for 2026-27 and following the introduction of new sub-national planning structures which align financial planning at a regional level

7.4 The Health Board remains at Stage 3 of the Scottish Government's Support and Intervention Framework. This status continues to be reviewed and an updated position is expected to be confirmed following submission of the financial plan for 2026-27.

7.5 The draft plan was considered by the Resources & Performance Committee at its meetings held on 5th March and 19th March. A final plan is expected to be presented to the committee at its next meeting scheduled for 7th May 2026.

7.6 There is no change to the brokerage position set out in previous reports. NHS Borders continues to hold a cumulative brokerage liability of £48.83m[3]. The current financial framework requires that repayment is made after achievement of a balanced financial position. No change to this arrangement has been indicated at present.

[3] Amended from £49.33m previously reported following clarification of prior year support by Scottish Government.

8 Key Risks

8.1 In line with the issues noted above, financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 547). Although the in year risk has been mitigated significantly through the actions set out within the paper, the underlying financial sustainability of the Board remains challenging. A refreshed risk assessment is being prepared in concert with the medium term financial plan.

8.2 As set out in previous reports, management of operational in year performance and long term sustainability will be separately considered under the refreshed risk assessment and updated on the organisation's risk register.

8.3 The in year financial performance reported for 2025-26 is now considered substantially mitigated through actions identified in year. As reported these actions remain non-recurring in nature, highlighting the continued risk to long term financial sustainability.

Appendices

- Appendix 1 – Income and Expenditure Analysis as reported to Scottish Government via FPR
- Appendix 2 – Key Expenditure Trends

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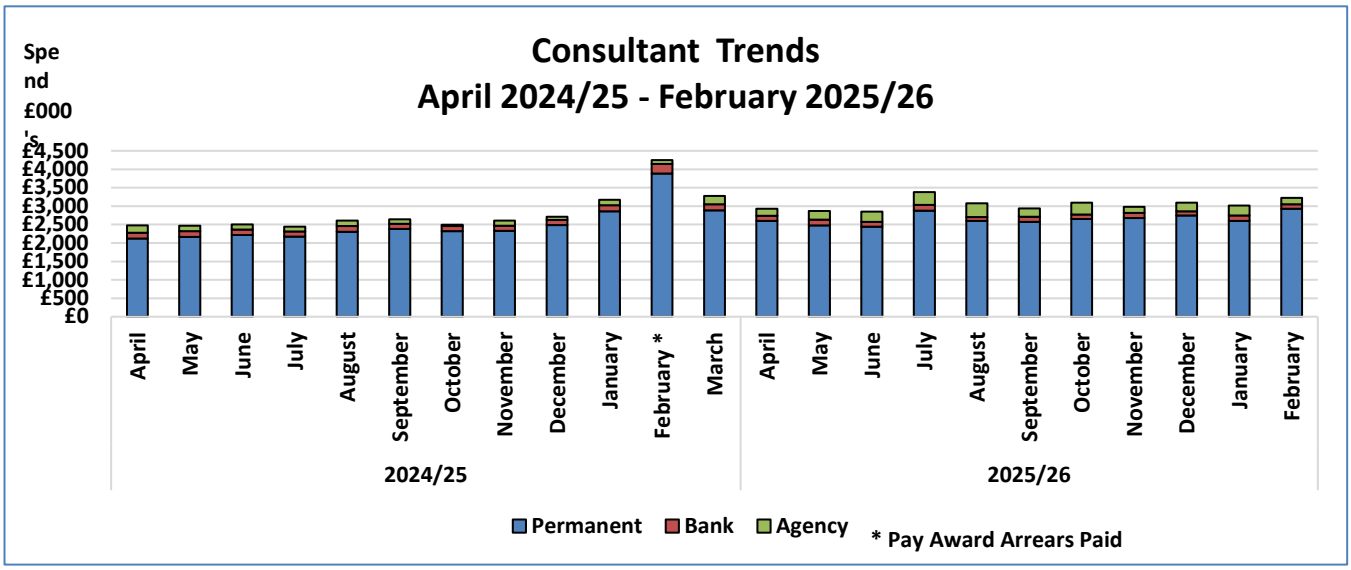
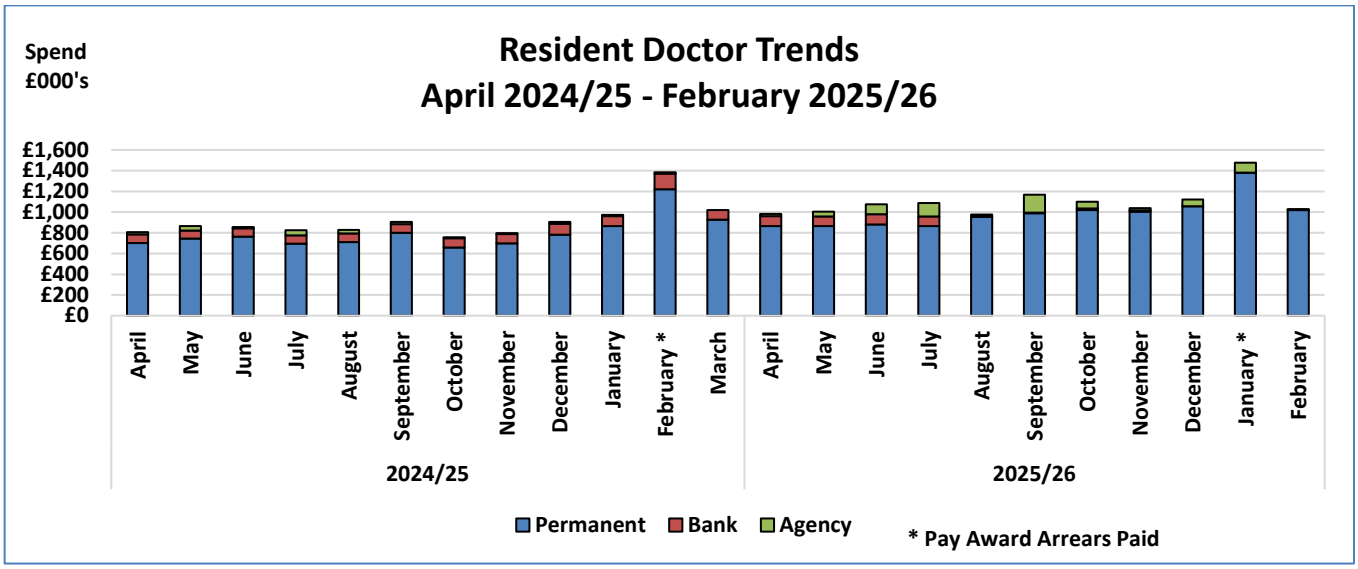
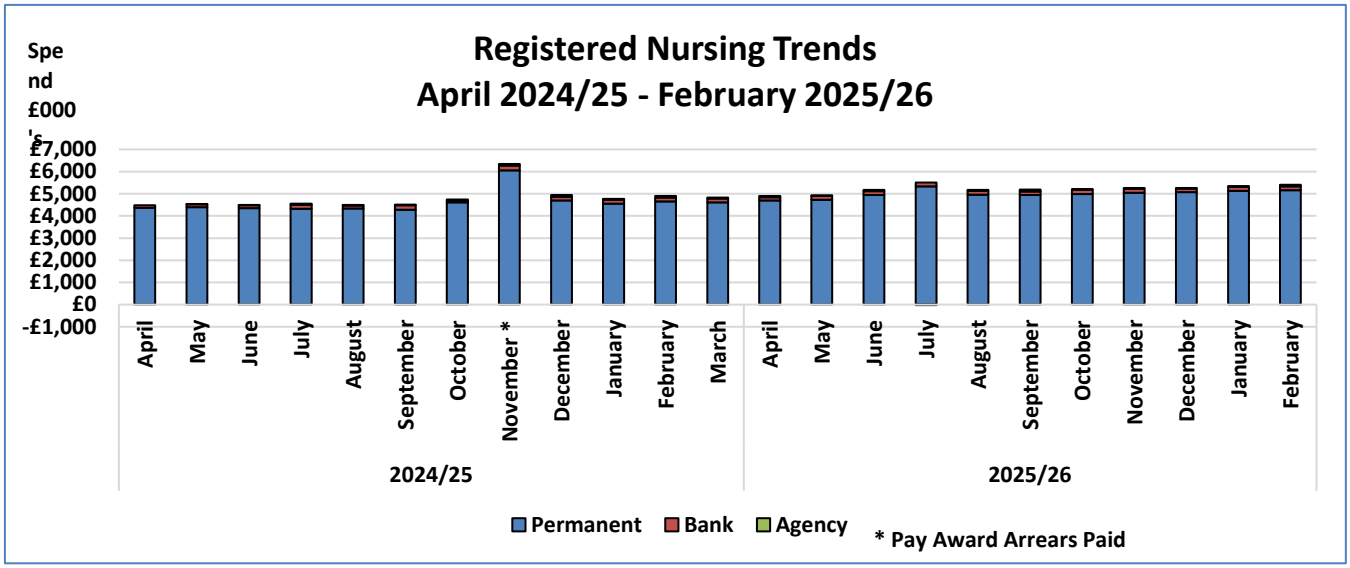
Appendix 1 – Income and Expenditure Analysis as reported to Scottish Government via FPR

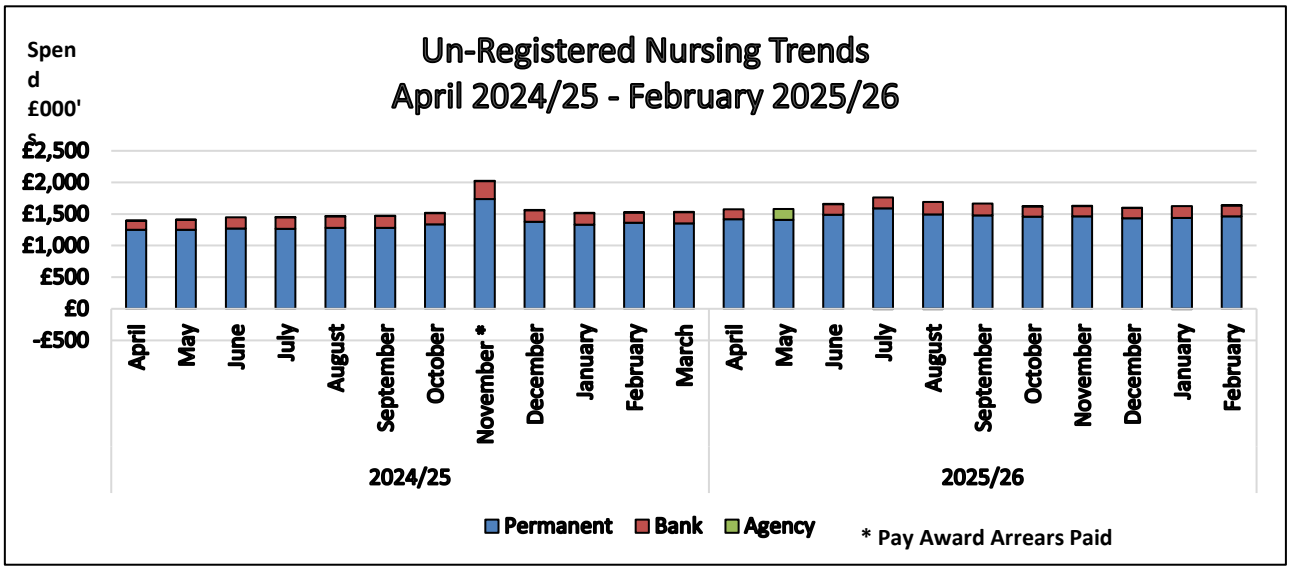
	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Pay					
Medical & Dental	42.78	47.16	43.28	44.85	(1.57)
Nursing & Midwifery	72.78	83.09	76.00	75.35	0.65
Other	69.66	83.68	76.62	71.18	5.45
Sub-total	**185.22**	**213.93**	**195.90**	**191.38**	**4.52**
Non Pay					
Independent Primary Care Services					
General Medical Services	22.94	26.12	23.92	23.91	0.01
Pharmaceutical Services	4.02	7.06	6.47	6.47	0.00
General Dental Services	5.75	9.70	8.89	8.89	(0.00)
General Ophthalmic Services	1.63	2.30	2.12	2.12	(0.00)
Sub-total	**34.35**	**45.17**	**41.39**	**41.38**	**0.01**
Drugs and medical supplies					
Prescribed drugs Primary Care	25.72	27.13	24.99	25.90	(0.91)
Prescribed drugs Secondary Care	14.10	17.93	16.51	16.51	(0.00)
Medical Supplies	7.31	10.16	9.34	9.79	(0.45)
Sub-total	**47.13**	**55.22**	**50.83**	**52.20**	**(1.36)**
Other health care expenditure					
Goods and services from other NHSScotland bodies	34.27	36.43	33.43	34.36	(0.92)
Goods and services from other providers	5.45	6.03	5.50	7.32	(1.82)
Goods and services from voluntary organisations	0.17	0.17	0.16	0.17	(0.01)
Resource Transfer	2.81	2.79	2.56	2.55	0.01
Loss on disposal of assets	0.00	0.00	0.00	0.00	0.00
Other operating expenses	44.60	40.38	16.24	25.82	(9.57)
External Auditor - statutory audit fee & other services	0.00	0.00	0.00	0.29	(0.29)
Sub-total	**87.30**	**85.81**	**57.89**	**70.50**	**(12.61)**
Income Analysis					
Income from other NHS Scotland bodies	(6.39)	(8.82)	(7.54)	(8.09)	0.55
Income from NHS non-Scottish bodies	(2.73)	(2.79)	(2.54)	(2.52)	(0.02)
Income from private patients	(0.06)	(0.06)	(0.06)	0.00	(0.06)
Patient charges for primary care	(11.41)	(19.06)	(17.47)	(17.47)	0.00
Non NHS					
Overseas patients (non-reciprocal)	0.00	0.00	0.00	0.00	0.00
Other	(4.17)	(9.09)	(7.16)	(7.35)	0.18
Total Income	**(24.76)**	**(39.82)**	**(34.77)**	**(35.43)**	**0.65**
Net Total Expenditure	**329.25**	**360.32**	**311.24**	**320.03**	**(8.79)**

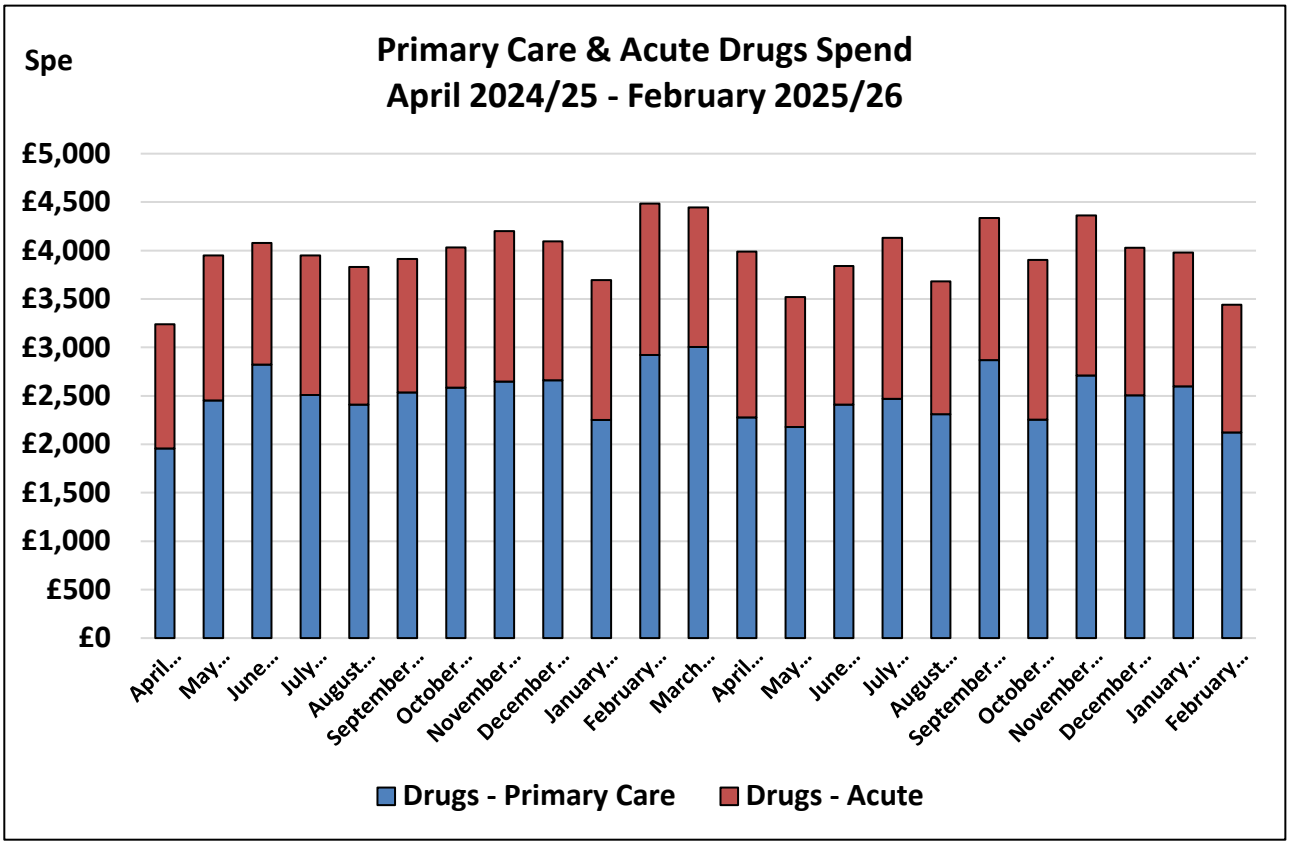
Appendix 2 - Key Cost Charts

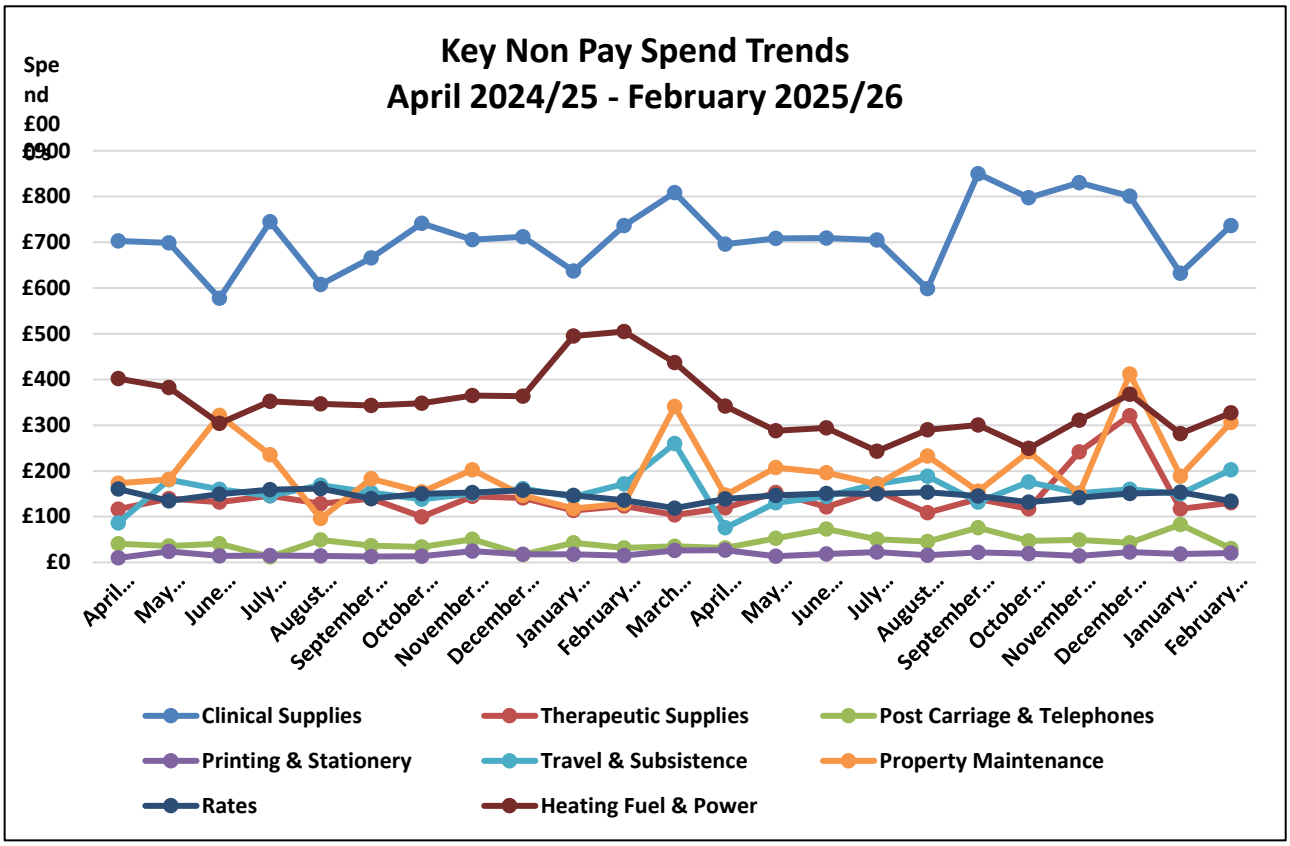







Un-Registered Nursing Trends
April 2024/25 - February 2025/26
Spend £000's
£2,500
£2,000
£1,500
£1,000
£500
£0
-£500
April
May
June
July
August
September
October
November *
December
January
February
March
2024/25
2025/26
Permanent
Bank
Agency
* Pay Award Arrears Paid


Primary Care & Acute Drugs Spend
April 2024/25 - February 2025/26
Spe
£5,000
£4,500
£4,000
£3,500
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
Drugs - Primary Care
Drugs - Acute


Key Non Pay Spend Trends
April 2024/25 - February 2025/26
Spend £000
£900
£800
£700
£600
£500
£400
£300
£200
£100
£0
April...
May...
June...
July...
August...
September...
October...
November...
December...
January...
February...
March...
April...
May...
June...
July...
August...
September...
October...
November...
December...
January...
February...
Clinical Supplies
Therapeutic Supplies
Post Carriage & Telephones
Printing & Stationery
Travel & Subsistence
Property Maintenance
Rates
Heating Fuel & Power

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Risk Appetite Policy**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality and Improvement**
Report Author:	**Laura Jones, Director of Quality and Improvement, Lettie Pringle, Risk and Effectiveness Manager, Ruth MacDonald, Risk and Effectiveness Coordinator, Rose Roberts, Risk Administrator**

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 and statements were refreshed in March 2025 for 2025/26.

A Board development session was held with NHS Borders Board on 5 February 2026 to consider the risk appetite policy and statements for 2026/27

Risk appetite is a matter reserved for the Health Board as per the Code of Corporate Governance and as such the Health Board are being asked to approve the revised Risk Appetite Policy including Appetite Statements for 2026/27 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 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.

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.

Following review of statements by the Board and Board Executive Team a suggested revision to one statement is proposed for 2026/27 to split the compliance category into 2 statements. The refreshed Risk Appetite Policy and statements should be used alongside the Risk Management Policy and the Risk Fund Framework.

Audit and Risk Committee gave a significant level of assurance that the Risk Appetite Policy and statements are set appropriately for 26/27.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

The Risk Appetite Policy is a supporting document to the NHS Borders Risk Management Strategy and the NHS Borders Risk Management Policy.

2.3.5 Equality and Diversity, including health inequalities

Previous HIIA remains relevant and is complete.

2.3.6 Climate Change

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

2.3.7 Other impacts

No other relevant impacts.

2.3.8 Communication, involvement, engagement and consultation

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

2.3.9 Route to the Meeting

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

- Board Executive Team, 18 March 2025
- Board Development Session, 5 February 2026
- Audit and Risk Committee, 23 March 2026

2.4 Recommendation

- **Decision** – The Healthboard is asked to approve the updated Risk Appetite Policy.

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Risk Appetite Policy

NHS Borders Risk Appetite Policy

File Name:	Risk Appetite Policy
Version Number:	V1.4
Status:	Approved
Prepared By:	Risk Team
Distribution date:	February 2026
Review date:	February 2028
Distribution arrangements:	Intranet

This policy has been approved for NHS Borders

……..

Chief Executive

……..

Employee Director

Approval date: 2026
Authorisation date: 2026

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
V1.4	19 March 2026	Risk Team	Amendments following statement reviews for 26-27

AUTHORISING CONTROL

Document Control

Document Name:	Risk Appetite Policy
Version Number:	v1.4
Date Created:	17th August 2023
Date Last Amended:	19th March 2026
Approved By:	*Borders Delivery 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.

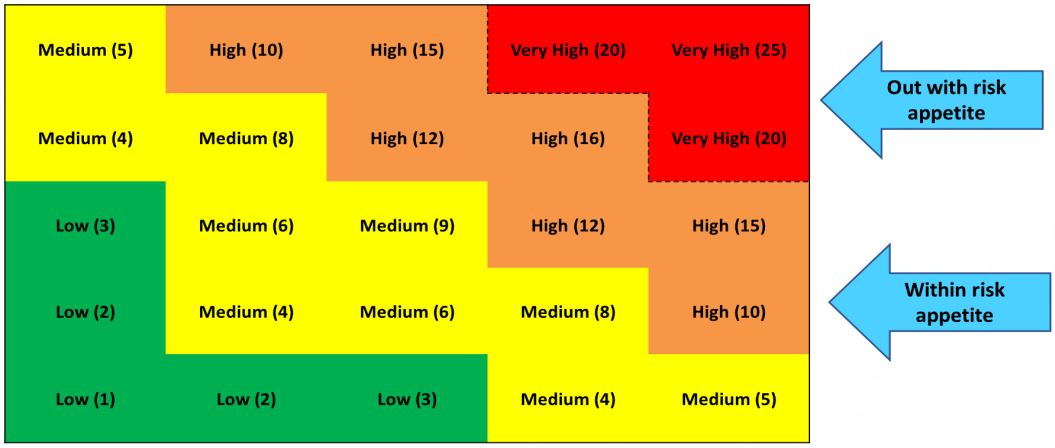
[1] (ISO Guide 73:2009 Risk Management – Vocabulary).

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 relevant management board either Hospital Management Board, Community & Mental Health Management Board or Corporate Services Huddle and where the risk fund is in use by the Operational Planning Group.

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 categories of risk 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 Hospital Management Board, Community & Mental Health Management Board or Corporate Services Huddle as appropriate, with escalation available 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 escalating 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 risk approver identified for their department or 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 Hospital Management Board, Community & Mental Health Management Board or Corporate Services Meeting to ensure risk information is accurate and no additional support can be given;
- If the Hospital Management Board, Community & Mental Health Management Board or Corporate Services Huddle cannot reduce the risk level, or where a risk has a current and target risk level of very high the risk should be escalated to the Operational Planning Group.

7.1.2 As part of the scrutiny provided by the Hospital Management Board, Community & Mental Health Management Board or Corporate Services Huddle or the Operational Planning Group 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. The expectation would be that risks of this nature which are escalated to the Operational Planning Group would already have been thoroughly reviewed by the Hospital Management Board, Community & Mental Health Management Board or Corporate Services Huddle to ensure all appropriate actions within their delegated authorities had been taken.

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 Delivery Group is required.

7.2 High Operational Risks

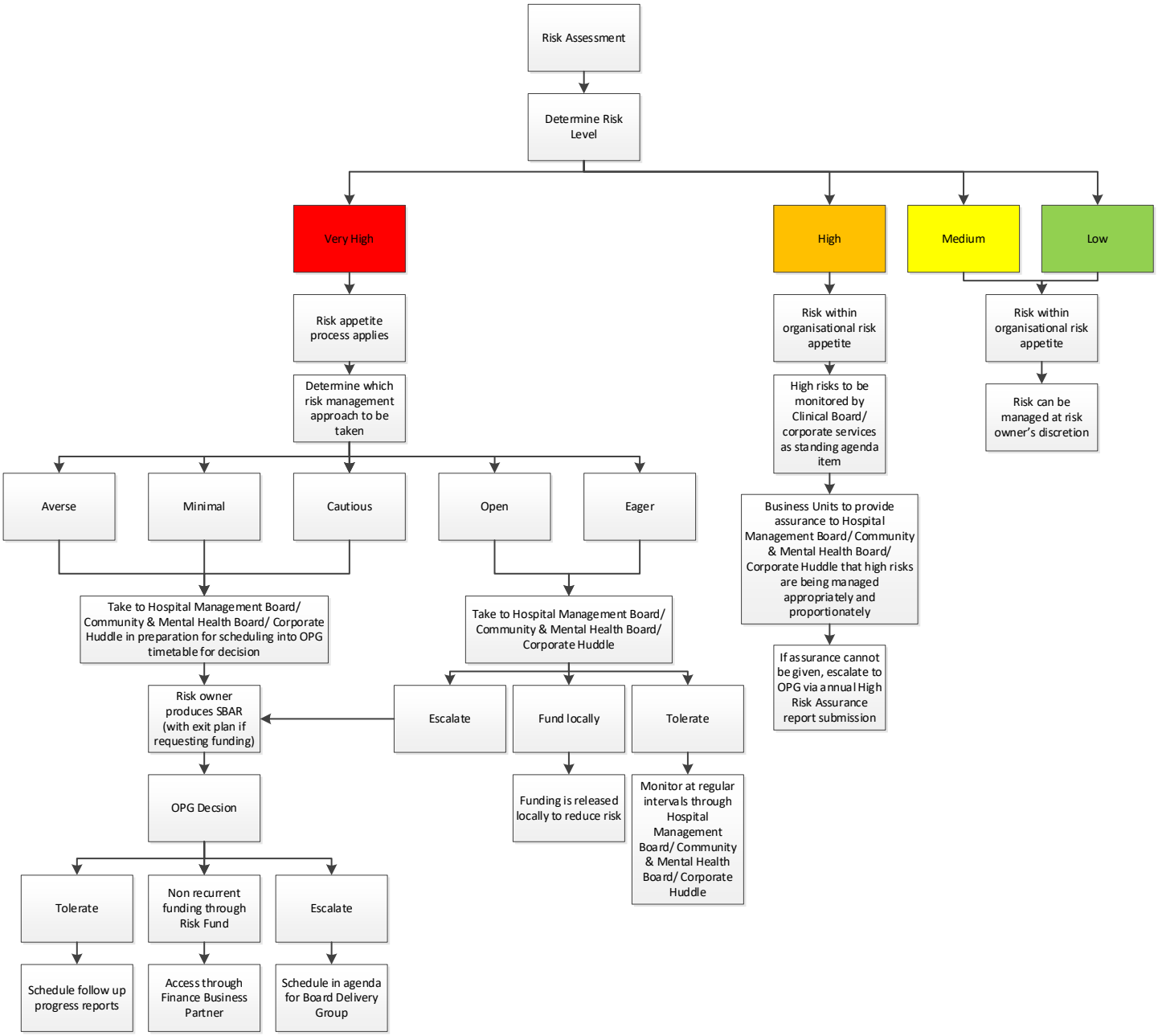
7.2.1 Governance of high risks will be achieved through business units as standing items on Hospital Management Board, Community & Mental Health Management Board and the Corporate Services Huddle agendas. These groups will have responsibility for oversight of high risks within their areas and will require assurance these are being managed appropriately and proportionately.

7.2.2 To support this work, a bi-annual operational risk report covering very high and high risks will continue to be fed into the Audit and Risk 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

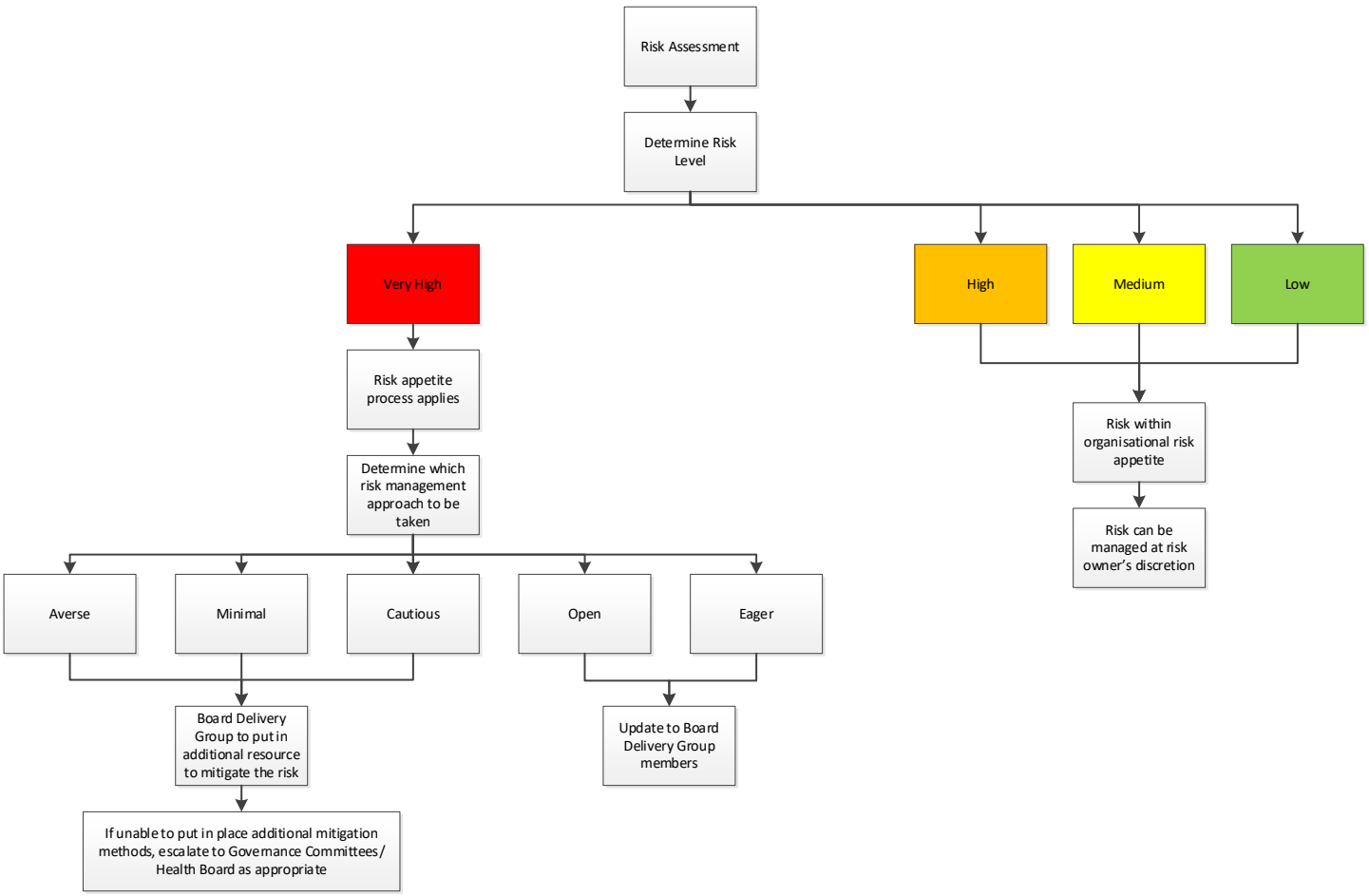
8.1.1 The Board Executive Team should scrutinise risks belonging to other members of the Board Executive Team to ensure that adequate resources are in place to mitigate risk. If it is deemed appropriate and mitigation is not possible, these risks should be escalated to the appropriate Governance Committee/Health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

8.1.2 Strategic risks within organisational risk appetite will continue to be fed into the Board Executive Team and on to Board Delivery Group as well as the appropriate Board 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 designed 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, as appropriate, to the Hospital Management Board, Community & Mental Health Management Board, Corporate Services Huddle or Operational Planning Group to agree an approach to minimise the risk. Where the risk fund has been deployed to support a risk, reporting to the Operational Planning Group will be required.

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

Diagram 4: Risk Category - Appetite Statements

	Risk Appetite Statement	Risk Approach
Strategy	NHS Borders has an **eager** stance to risks arising from the pursuit of their strategic objectives, recognising the scale of transformation required to sustain health services.	Eager
Governance	NHS Borders takes a **cautious** stance to governance and is receptive to making and acting upon difficult decisions when the benefits outweigh the risks when clear plans/priorities/accountabilities are in place and where decision-making oversight is proportionate and effective.	Cautious
Operations	NHS Borders has an **open** stance to delivering services supported by innovative solutions and supports decision-making at local level where there is a positive impact on financial sustainability and patient and staff safety.	Open
Legal	NHS Borders has a **minimal** stance to risks arising from a defective transaction or a claim being made (including a defence to a claim or a counterclaim).	Minimal
Compliance	NHS Borders has adopted a **minimal** stance for compliance, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk as far as reasonably practicable within given capacity. This includes risks arising from inadequate, poorly designed, or ineffective/inefficient internal processes resulting in poor quality care, unacceptable risk to patients or staff, non-compliance with standards, poor clinical / professional practice, fraud, error and/or poor value for money. Where a compliance risk does not negatively impact on patient or staff safety, quality of care and there is no presence of criminality, the Board will give consideration to a **cautious** approach supported by a robust review of the resources required to address the risk and resulting impact on other areas of service delivery.	Minimal Cautious
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

	Risk Appetite Statement	Risk Approach
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**
Technology	NHS Borders has adopted an **open** stance to technological risks where proven technologies are considered to enable improved operational delivery. 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.	Open 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; - 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
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
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

	Risk Appetite Statement	Risk Approach
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
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

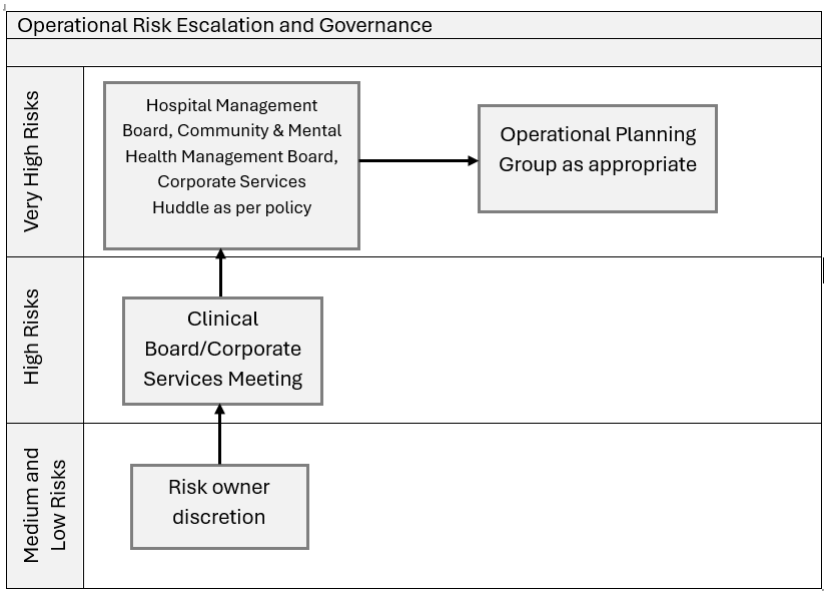
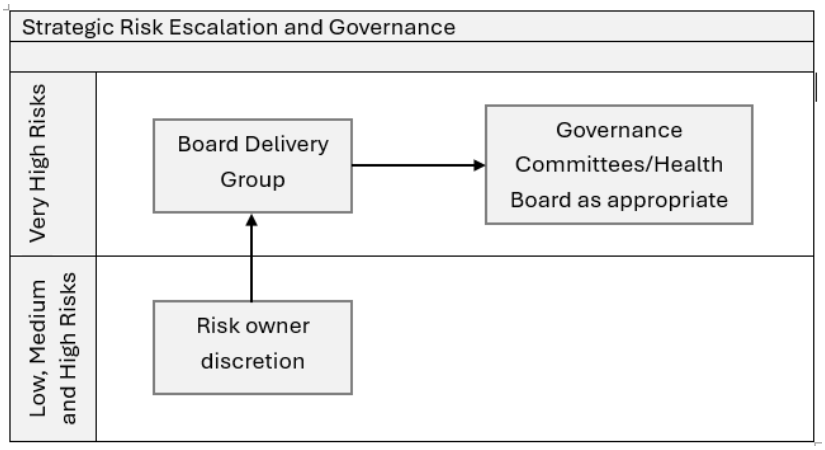


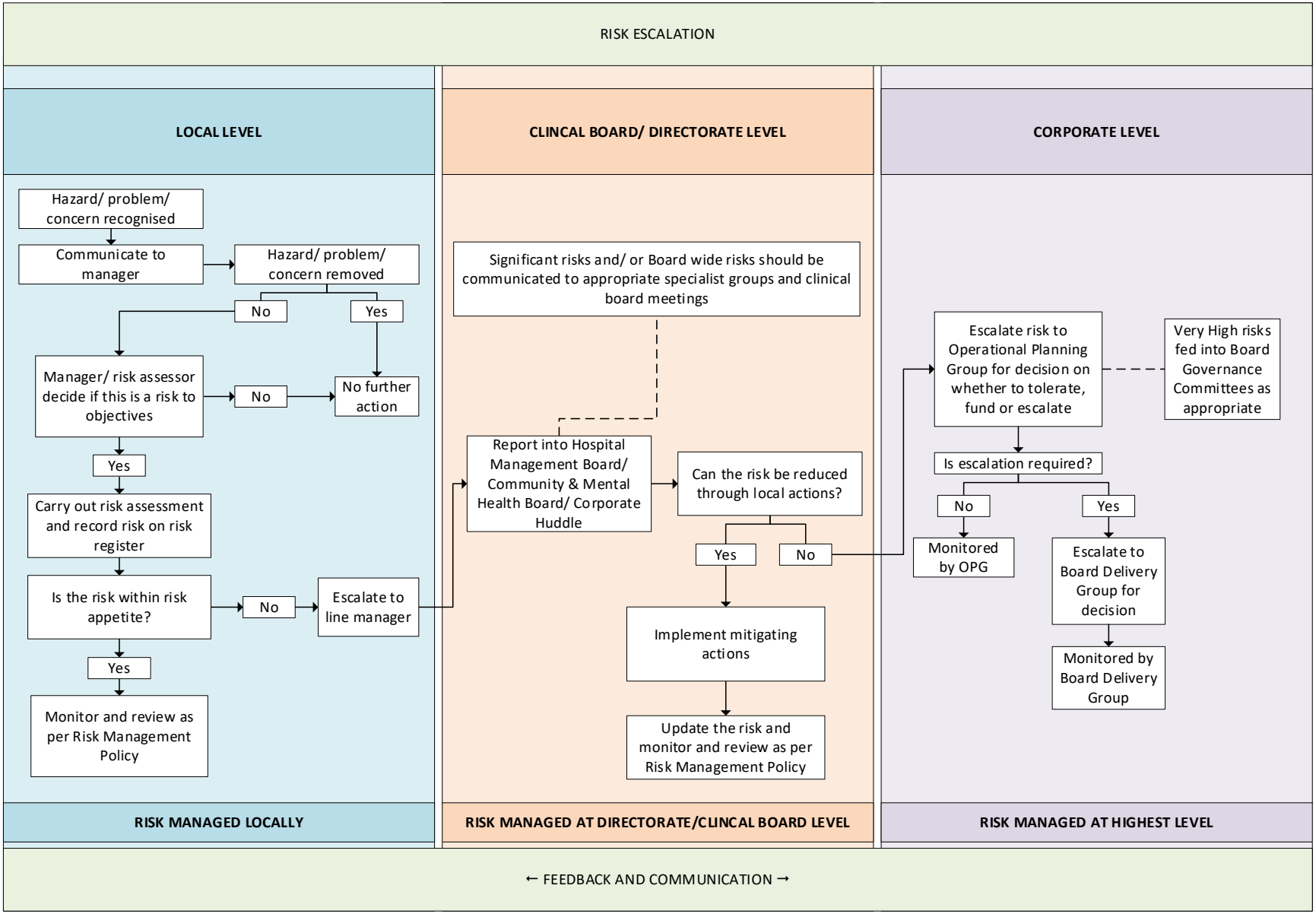
Diagram 6: Strategic risk escalation and governance



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 relevant meeting groups 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:	**2 April 2026**
Title:	**Clinical Governance Committee Minutes**
Responsible Executive/Non-Executive:	**L Jones, Director of Quality & Improvement**
Report Author:	**I 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 25 March 2026

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Clinical Governance Committee minutes 14.01.26

Borders NHS Board
Clinical Governance Committee

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 14 January 2026** at 10am via Microsoft Teams

Present

Fiona Sandford, Non-Executive Director (Chair)
Paul Williams, Non-Executive Director
Lucy O'Leary, Non-Executive Director

In Attendance

Rose Roberts, PA to Director of Quality & Improvement (Minute)
Laura Jones, Director of Quality & Improvement
Sohail Bhatti, Director of Public Health
Oliver Bennett, Interim Director of Acute Services
Olive Herlihy, AMD/Director of Medical Education
Caroline Cochrane, Director Psychological Services
Jonathan Manning, Associate Medical Director, Planned Care
Imogen Hayward, Associate Medical Director, Unscheduled Care
Peter Lerpiniere, Associate Director of Nursing, Mental Health, & Learning Disabilities
Philip Grieve, Interim Associate Director of nursing, Acute Services
Kirsteen Guthrie, Associate Director of Midwifery & GM for Women & Children's Services
Julie Campbell, Lead Nurse for Patient Safety and Care Assurance
Sam Whiting, Infection Control Manager

1 Apologies and Announcements

Apologies were received from:
Amanda Cotton, Associate Medical Director, Mental Health Services (virtual attendee)
Lynne Livesey, Non-Executive Director
Sarah Horan, Director of Nursing Midwifery and Allied Health Professionals
Rebecca Green, Associate Medical Director – Primary and Community Services
Peter Moore, Chief Executive
Lynn McCallum, Medical Director
Malcolm Clubb, Director of Pharmacy
Gareth Clinkscale, Director of Urgent Care, Community Services and Mental Health

The Chair confirmed the meeting was quorate.

The Chair welcomed:

Cathryn Park, Deput Director of Pharmacy; Rhona Morrison, Quality Improvement Facilitator – Medicines Governance and Shelley Scott, Controlled Drug Governance Officer:
Pharmacy update (item 5.5)

Helen Adams, Transfusion Practitioner and Andrew Shepher, Consultant:
Blood Transfusion Annual Update (item 5.6)

Susan Elliot, Alcohol & Drug Partnership Co-Ordinator and Rebecca Norris, Wellbeing Service Advisor:
Drug Deaths annual update (item 5.8)

Cathy Wilson, General Manager – Primary & Community Service- Strategic Risk:
PACS & Independent Contractors (item 6.3)

Michelle O'Reilly, Chief Nurse – Clinical and Professional Development

There were no announcements from the Chair.

2 Declarations of Interest

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

2.1.2 The **CLINICAL GOVERNANCE COMMITTEE** noted there were no declarations made.

3 Minute of Previous Meeting

3.1.1 The minute of the previous meeting of the **Clinical Governance Committee** held on **Wednesday 12 November 2025** was approved, after one change to section 5.2.2.

4 Matters Arising/Action Tracker

4.1.1 Matters Arising from the previous meeting were noted and action Tracker was updated accordingly.

5 Effectiveness/Annual Assurance

5.1 Clinical Board update – PCS Services

5.1.1 K Steward highlighted the considerable operational pressures affecting Primary & Community services, particularly over recent weeks when high levels of staff sickness significantly affected business continuity. Small teams such as School Nursing, CTAC and SLT are especially vulnerable to minor fluctuations in staffing and this has affected both clinical activity and governance tasks.

5.1.2 School Nursing was noted as an area of particular concern. The team had moved to a black RAG status earlier in the year due to compounding pressures of workforce gaps, rising numbers of children requiring safeguarding oversight, and escalating emotional-wellbeing referrals. Waiting times for emotional support had reached approximately 40 weeks, representing almost an entire school year. The Committee welcomed early interventions such as the planned roll-out of the ChatHealth digital platform, revised referral processes and a workforce review in partnership with HR.

5.1.3 Hospital at Home continues to make progress, stabilising at 20 virtual beds, with planned expansion to 25 once a new specialty doctor commences in March. Members also heard that staffing constraints across community teams have impacted mandatory training and appraisal compliance rates; targeted support is now being offered to ensure improvement.

5.1.4 The Chair asked for further clarification on School Nursing pressures and whether the 40-week waiting list could be reduced through any short-term mitigations. It was confirmed that a comprehensive update will be brought to a future meeting, including options for alternative delivery models.

5.1.5 ACTION: Committee requested an update on the Primary Care Improvement Plan at the next meeting.

5.1.6 ACTION: Committee requested a detailed update on School Nursing pressures, waiting-list mitigation options and digital interventions in future reporting.

5.1.7 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

5.2 Clinical Board update – MH& Psychological Services

5.2.1 P Lerpiniere gave a brief update on the paper noting that CAMHS has continued to maintain RTT performance around the 95% standard, which is a significant improvement compared to previous years. However, ND assessments remain a sustained challenge, with demand continuing to outstrip available capacity despite new internal pathway work including linking with schools and social work to ensure the best support is available for children. S Bhatti requested assurance regarding neurodiversity definitions and the risk of over-pathologising young people. It was confirmed that this is being considered within the whole-system pathway redesign.

5.2.2 The Chair requested further detail on national CAMHS inpatient capacity and implications for Borders. It was confirmed that significant pressure on young people's inpatient beds was continuing across Scotland. Members heard that two national units are operating with reduced capacity following joint HIS/MWC inspections, which is further increasing demand on local psychiatric settings. It was confirmed that local restraint practices have been reviewed in light of national scrutiny and remain safe, rarely used and complaint with best-practice guidance.

5.2.3 Workforce pressures continue, particularly in adult community mental health teams where reliance on locum staffing remains high. Quality assurance work in mental health inpatient wards is progressing, and the Committee welcomed the appointment of the Consultant Nurse in General Adult Psychiatry.

5.2.4 A short-term change in suicide numbers was highlighted. It was also noted that whilst completing Significant Adverse Event Reviews in time is difficult an immediate review on practice has been started regarding a recent inpatient death by suicide to consider whether anything can be done to improve safety. S Bhatti asked whether GPs are now consistently involved in adverse event reviews. It was confirmed this is now routine practice within Mental Health.

5.2.5 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

5.2.6 Psychological Services

5.2.7 L Keir reported that the Psychological Services Directorate has completed its service review and is now advancing implementation planning. Governance arrangements are

being strengthened through development of topic-specific groups and representation of psychological services on all clinical governance boards. This is intended to align escalation pathways and reduce fragmentation. P Williams asked whether new governance structures would strengthen escalation. It was confirmed that this was the intention.

5.2.8 It was highlighted that waiting-list performance improved to 80% in November following successful recruitment to fixed-term posts and onboarding of short-term locums. Sickness absence, which had peaked to almost 10% during the winter period, has now improved. Digitalisation work is underway, including enhanced deployment of SilverCloud and NearMe as part of an organisation-wide QI approach. S Bhatti asked about the scope and pace of digital expansion. It was confirmed that this will be driven by the newly appointed senior psychologist.

5.2.9 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

5.3 Clinical Board update – LD Services

5.3.1 P Lerpiniere provided a brief overview of the Learning Disabilities paper, highlighting significant progress in some areas but continued complexity in others. Recruitment work for expanding the LD team has progressed, with the aim of enabling more individuals to remain safely within Borders and reducing reliance on out of area placements. However, recruitment difficulties continue to affect the Coming Home Project, and the committee acknowledged that there is a risk for some placements reverting to out of area arrangements. It was noted that a dynamic decision-making support tool used in England is being trialled, to assist in decision making around financing between NHS Borders and Scottish Borders Council.

5.3.2 Annual Health Checks continue to be rolled out with support from a recently recruited administrator. S Bhatti queried whether annual health checks capture those not known to LD services. It was confirmed that there is still a gap in regard to reaching less visible populations, and that further work is required.

5.3.3 The National mortality review processes for LD services are expected to be implemented in Spring 2026, requiring preparation to ensure compliance. The LD Liaison Service continues to provide significant support to BGH teams, handling approximately 17 referrals per month despite limited staffing. The LD service is currently on track to reach their saving commitments.

5.3.4 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

5.4 Clinical Board update – Acute Services

5.4.1 P Grieve highlighted that Senior Charge Nurse Lynsey Russel has been awarded an MBE for her services to nursing. The committee extended their congratulations to Lynsey for this achievement.

5.4.2 P Grieve provided an update describing severe operational pressures affecting acute services over the winter period. High bed occupancy, high acuity, and staffing shortages have placed considerable strain on teams. ED performance deteriorated significantly in the weeks following Christmas, with the number of patients waiting more than 12 hours

reaching the highest level seen locally in two years. S Bhatti enquired about data-linking for patients experiencing corridor care and impacts this may have on their outcomes. O Bennett confirmed that national evidence around this is strong but that local dashboards can summarise the impact.

5.4.3 Falls with harm and pressure damage incidents had increased. It was confirmed that these incidents were distributed across several areas rather than concentrated in one ward, and the workforce shortages were a major contributing factor. Workforce tool triangulation and professional-judgement reviews will be presented to the Hospital Management Board.

5.4.4 The Committee welcomed the opening of the Frailty Unit in December and noted the positive impact this is expected to have on system flow. However, due to increasing pressures the Medical Assessment Unit is still operating differently from its intended high-turnover design.

5.4.5 O Bennett highlighted that performance in the prostate cancer pathway has improved significantly following additional administrative support, with Borders moving from the bottom to near the top of the national league tables. Stroke performance has also improved, though further work is required at whole-system and multi-system levels. The Chair requested a written update on stroke and prostate cancer pathways. It was confirmed that this will be provided.

5.4.6 P Williams asked whether Early Supported Discharge work should primarily be overseen through the Resources and Performance Committee, noting its role within urgent and unscheduled care delivery. He highlighted that where Early Supported Discharge directly impacts the stroke pathway, this remains a clinical quality and patient safety issue and should continue to receive assurance through the Clinical Governance Committee. L Jones confirmed that this work is feeding into the Resources and Performance Committee. The Chair acknowledged the point and agreed that continued visibility through the Clinical Governance Committee was appropriate for stroke-related pathway assurance. The committee was informed that further work is being undertaken to clarify reporting boundaries between Committees.

5.4.7 K Guthrie gave an update on Women's and Children's services noting that there has been a rise in gynaecology complaints. The Chair requested that more detail regarding this is returned to a future Clinical Governance Committee. It was confirmed that a deep dive is underway, and that this will be included in a future paper. It was also highlighted that CTG funding has been supported by the Training, Education and Development Board to allow this training to continue through 2026.

5.4.8 The committee delivered congratulations to the staff who worked tirelessly over the festive period to ensure patients were as safe as possible. The Committee also noted that a new SOP for SAERs and a new weekly action tracker for complaints are two new implemented processes that should improve performance. The Committee welcomed news that the Acute Clinical Governance Board has been strengthened by P Grieve.

5.4.9 ACTION: Discuss Acute Clinical Governance paper structure to ensure updates around stroke service match requirements

5.4.10 ACTION: Committee requested a written update on the Prostate Cancer Pathway, including sustainability of recent improvements.

5.4.11 ACTION: Committee requested a written update on the Stroke Pathway, including analysis of the impact of whole-system flow issues.

5.4.12 ACTION: Committee requested the themes and learning from the gynaecology complaints deep dive is included in a future report.

5.4.10 ACTION: A statement to be included in the next acute paper on harm post-Christmas compared to typical months to help inform seasonal planning for next year.

5.4.11 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

5.5 Corporate Clinical Support Services update – Pharmacy

5.5.1 C Park presented the pharmacy governance update, noting that recent internal audit work had identified areas requiring strengthened controls, particularly in relation to paper-based prescribing, medication error reporting culture and osteoporosis pathways. The Committee acknowledged the need for interim governance solutions pending the long-term implementation of HEPMA, currently forecast for 2030. The Chair asked for clarification on risk mitigations due to the extended HEPMA timescales. It was confirmed that interim measures are being explored.

5.5.2 It was noted that work continues to support polypharmacy reviews, although IT limitations in secondary care remain a barrier to consistent data extraction. The importance of ensuring appropriate training and induction for junior doctors to prevent medication related risks was emphasised to the committee. S Bhatti asked whether polypharmacy work could better reflect health inequalities. C Park welcomed joint work with Public Health.

5.5.3 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

5.6 Agenda item – Blood Transfusion Annual Assurance Report

5.6.1 H Adams and A Shepherd outlined progress made in transfusion governance, including working on lessons from the Infected Blood Inquiry, mandatory training and expansion of Band 6 transfusion support posts across NHS Scotland. The Committee noted the benefit these posts will provide in strengthening front-line training, investigation of incidents and local audit capacity.

5.6.2 It was confirmed that while the ageing donor population poses a long-term challenge, current stock levels remain stable. The Chair asked whether supply security was a current concern. Occasional pre-amber alerts have been issued nationally, but Borders has not experienced amber or red supply shortages.

5.6.3 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

5.7 Agenda Item - Suicide Prevention Annual Assurance Report

5.7.1 C McElroy presented an overview of suicide prevention activity, highlighting the ongoing alignment with the national Creating Hope Strategy and strengthened partnership

working across public health, mental health, third-sector organisations and Police Scotland. Improvements in real-time surveillance data were noted, with the QES system enabling more timely responses to individuals in distress.

5.7.2 The Committee discussed the importance of early intervention and recognised the emotional impact of suicide on staff, families and communities. Members welcomed the enhanced training offer (including ASSIST and self-harm modules) and noted the need for continued collaboration between MH and PH teams. The Chair queried whether real-time surveillance is now sufficiently robust to support early action. Significant improvements in both data quality and responsiveness were confirmed.

5.7.4 S Bhatti highlighted the limitations of predictive risk assessment in suicide prevention and emphasised the importance of recognising wider societal and contextual determinants, including poverty, isolation, resilience and community support. He noted that General Practice and community services may hold valuable intelligence which could further inform learning from suicide reviews. P Lerpiniere acknowledged these points and confirmed that national confidential inquiry findings support the limited effectiveness of predictive risk tools. He advised that services are increasingly focusing on person-centred, strengths-based care planning, with an emphasis on identifying protective factors and what helps individuals remain safe. He further noted that this approach is being progressed in partnership with other Boards and national programmes, and that learning from suicide reviews continues to inform both local and national improvement work.

5.7.5 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

5.8 Agenda Item – Drug Deaths Annual Assurance Report

5.8.1 S Elliot presented the Drug Related Deaths report, noting that 2024 saw the lowest number recorded in Borders since 2013. However, early 2025 toxicology suggests a shift toward increased involvement of stimulants, nitazines and pregabalin, requiring heightened vigilance.

5.8.2 The Committee welcomed positive performance in MAT with 81% same day initiation and the strong functionality of the near-fatal overdose pathway. Workforce wellbeing initiatives were noted as important given the emotional toll of this area of work. O Bennet queried the sustainability of current improvement work. The committee was advised that national mission funding is confirmed for one further year but future resourcing is not yet known.

5.8.3 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Significant Assurance** for processes, recognising ongoing system risks.

6 Patient Safety

6.1 Infection Control Report

6.1.1 S Whiting provided an update on infection control performance, highlighting early and intense flu activity across Borders consistent with national trends. He noted that one infection control nurse had been redeployed to support estates redevelopment, which has reduced audit and care home support capacity. The Chair asked about the

operational impact of reduced audit capacity. It was confirmed that while capacity had decreased, prioritisation ensures that highest-risk areas continue to receive oversight.

6.1.2 The CAUTI Task and Finish Group is meeting fortnightly with initial actions progressed including policy review and testing of new documentation in the Frailty Unit. The ongoing work of orthopaedic colleagues in reviewing SSIs from 2024, with learning being captured was also acknowledged. This will be repeated for 2025 data in January of 2026, and the plan is then to report this data more timeously.

6.1.3 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

6.2 Agenda Item – Strategic Risk – Whole System

6.2.1 L Jones and O Bennett presented the whole system flow update, noting the considerable progress achieved through implementation of the Frailty Unit, Integrated Discharge Team, Hospital at Home expansion and development of Home First. Although seasonal pressures have temporarily masked some benefits, the Committee agreed these interventions are essential foundations for sustainable improvements. The Chair sought clarity on the appropriate scale for Home First as it had been referenced that even with expansion it may not yet be at an appropriate size. The committee was advised that DCAQ modelling will determine optimal capacity.

6.2.2 The Committee noted the substantial investment made by Scottish Borders Council and the significant impact it has had on success of flow improvement. They discussed concerns about long-term affordability. It was agreed that cross system work within the IJB must continue to explore solutions that are both clinically and financially sustainable. L O'Leary asked how funding responsibilities between NHS Borders and SBC should be managed going forward. The Chair confirmed discussions are planned with IJB leadership.

6.2.3 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Significant Assurance** for the systems and processes but **Limited Assurance** for the current outcomes.

6.3 Agenda Item – Strategic Risk – PACS & Independent Contractors

6.3.1 C Wilson presented an update noting that the landscape has changed significantly since this risk was first highlighted. She highlighted that there has been an improvement in GP, dental, pharmacy and ophthalmology workforce stability since the post-pandemic peak. The Committee welcomed this improved position and agreed that the wording of the risk should be reviewed to reflect the current landscape.

6.3.2 The Committee extended congratulations to Morag Muir for her appointment as the Deputy Chief Dental Officer for Scotland.

6.3. The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Significant Assurance**

6.4 Agenda Item – Adverse Event Overview

6.4.1 J Campbell summarised performance against the revised National Adverse Events Framework. The Committee acknowledged continued challenges in commissioning and

completing Level 1 SAERs within timescales, largely due to reviewer capacity and the specific requirements for external reviewers in maternity and suicide cases. It was confirmed that a full gap analysis has been completed and proposals will be brought forward to expand the reviewer pool and strengthen family engagement to improve capacity and meet national timeframes.

6.4.2 NHS Borders and the other health boards set out these issues for the Scottish Government and Healthcare Improvement Scotland but this did not lead to any changes to the expected timescales. This means NHS Borders will now need to consider further what structure will need to be put in place to meet these expectations.

6.4.3 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

7 Items for Noting

The **CLINICAL GOVERNANCE COMMITTEE** noted the items listed below:

Clinical Governance Committee Draft Workplan
ASBC Governance Minutes 28.10.2025
LD Governance Minutes 10.09.2025, 05.11.2025
P&CS Governance Minutes 18.12.2025

8 Any other Business

There was no other competent business recorded.

9 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 25 March 2026** at **10am** via Teams Call.

The meeting concluded at 12:19

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Quality & Clinical Governance Report - March 2026**
Responsible Executive/Non Executive	**Laura Jones - Director of Quality and Improvement**
Report Author (s):	**Julie Campbell - Lead Nurse for Patient Safety and Care Assurance, Susan Hogg - Patient Experience Coordinator, Justin Wilson - Quality Improvement Facilitator Effectiveness, Susan Cowe - Senior Project Manager - 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 in areas by workforce and financial challenges, across the health and social care system.

2.3 Assessment

2.3.1 Clinical Effectiveness
The Board CGC met on 25 March 2026 and discussed papers from all four clinical boards and corporate clinical support services.

2.3.2 The Committee received an update from Mental Health Services and noted a continued challenging operational picture driven by significant workforce pressures, limitations of regional resources and increasing demand for particular services. Child and Adolescent Mental Health Services (CAMHS) nursing vacancies remain a core concern, with a 3.8 WTE shortfall affecting waiting times and service resilience. Mitigation includes expanding Band 7 psychology roles and introducing Band 5 development posts, though benefits will take time to materialise. Adult mental health services remain reliant on locum consultants, while CAMHS has experienced further pressure due to the prolonged absence of its substantive consultant, partly mitigated by appointing a senior trainee to a permanent post. Ongoing national shortages in CAMHS inpatient provision, compounded by temporary bed closures at Skye House, continue to heighten the risk of young people being admitted to local adult inpatient areas such as Huntlyburn. Although recent cases were well managed, this presents and ongoing risk and the Committee were keen to remain appraised of how NHS Borders is influencing the national work on provision of inpatient beds. The Committee also noted wider governance activity across community teams, including the introduction of a nurse consultant role and strengthened clinical supervision. Despite active improvement work, the cumulative impact of workforce shortages, increasing demand and access to regional services resulted in the Committee taking **Limited Assurance**.

2.3.3 The Committee received an update from Psychological Services and recognised substantial progress in strengthening internal governance, workforce oversight and cross-organisational alignment, with no issues requiring urgent escalation. A key development welcomed by the Committee was the introduction of a new governance model assigning senior psychologists to designated roles across all major Clinical Boards, ensuring consistent psychological input and aligning with successful multidisciplinary approaches used elsewhere. The Committee noted further improvements arising from the integration of Psychological Therapies and Trauma-Informed Practice within the Quality and Safety Programme, reducing fragmentation and supporting clearer organisational alignment. Although workload pressures persist the service reported no deterioration in waiting lists or risk indicators. Strengthened supervision structures were also noted as supporting safe practice and continued professional development. Committee confirmed **Moderate Assurance** for the Psychology report.

2.3.4 The Committee received a paper on Learning Disability (LD) Services. The Committee noted that the service continues to highlight concerns relating to the ability to manage

patients under the coming home report effectively in the community due to staffing issues across the social care system and with external care providers. This is becoming increasingly complex to resolve and sustain local placements. The Committee were pleased to note that progress continues in relation to the national priority area of Annual Health Checks. The Committee noted the positive work the service has done to strengthen its governance foundation including nursing audits, regular workforce development activity, and the introduction of a new Power BI dashboard, improving visibility of caseloads. The Committee noted that recruitment prospects within the health roles in the LD team itself were positive, with strong candidate interest in roles. It was highlighted, however, that the more significant workforce fragility lies within the social care provider market, where shortages are impacting discharge pathways, community placement stability and transitions. On this basis the Committee took **Limited Assurance.**

2.3.5 The Committee received an update from Acute Services and noted that the operational environment remains highly pressured due to ongoing demand on unscheduled and planned care placing significant requirements on additional beds and clinical workforce. The Committee welcomed areas of improvement, including expansion of the stroke nurse service, progress in the prostate cancer pathway and early success of the acute frailty unit, which has contributed to improved frailty-to-home discharge performance. Variable completion of Care Assurance audits and assurance visits was acknowledged as this new system embeds, although Acute leadership reported recent improvement and a dedicated focus in this area. A 100-day focus programme will begin in April 2026 to target quality variation across key domains including pressure damage, complaints management and deteriorating-patient processes. Workforce challenges week discussed with reference to the nursing workforce pressures that are anticipated over the coming five years due to shortages in the number of nursing students coming through the system. This is compounded by some of the new pay reforms and reductions in working hours. This will require close monitoring across the varied roles nursing colleagues cover across NHS Borders to ensure local service need can be safely met. Mitigations are being worked on in relation to over recruitment where possible, international recruitment, skill mix and access to work schemes. Key risks were discussed and the ongoing work to ensure effective mitigation plans are in place for each. The Committee asked to receive an update on the specific risks identified including risks relating to nurse staffing, key medical workforce groups and diagnostic pressures in endoscopy. Reflecting the breadth of system pressure, the Committee assigned **Limited Assurance**.

2.3.6 The Committee received a report on Primary & Community Services (PCS) as well as a detailed deep dive into the pressures in the school nursing service requested at the last committee meeting. The school nursing service delivers safeguarding, universal health interventions and statutory assessments. Waiting times for routine mental-health-related referrals remain lengthy, and rising child-protection activity reflects increasing case complexity for the school nursing team. The Committee were assured by the range of work underway to understand the change profile of demand for the school nursing team and to look at how demand can be met and risk mitigated but remain concerned about the increase in demand on this small but important service and wished to stay appraised of this work. There were several areas of positive assurance in the wider PCS report with significant improvement resulting from the work to strength services for frailty through improvement work in Kelso community hospital, home first, hospital at home and the integrated discharge team. The Committee agreed **Moderate Assurance**.

2.3.7 The Committee considered the East Region Health Protection Services (ERHPS) Annual Report. The Committee considered the ERHPS Annual Report and noted the robust and effective delivery of statutory health protection functions across the East Region. Activity levels remain within expected parameters, with 3,870 cases managed regionally in the past year, including 419 from NHS Borders. Strong performance was highlighted during the national pertussis outbreak, alongside effective management of TB, environmental incidents and routine infectious diseases. The Committee welcomed positive performance and safety indicators, including no serious adverse events and timely management of all data-related incidents. The regional model continues to provide resilience for smaller Boards, enhancing surge capacity and reducing duplication. Work to formalise arrangements through an SLA between Borders and Lothian is underway. The Committee agreed **Moderate Assurance**.

2.3.8 The Committee reviewed the Allied Health Professionals (AHPs) Annual Report and noted strengthened governance, clearer escalation pathways and improved use of monthly Care Assurance dashboards. The paper focused on three key risks where targeted work has been undertaken including Children and Young People's Speech and Language Therapy where waits are exceeding 100 weeks for some interventions, unmet inpatient rehabilitation demand in inpatient areas, and issues with sustainability of the overnight respiratory physiotherapy service. The Request for Assistance model has successfully redirected some referrals to more appropriate provision, but reducing the remaining backlog requires additional time-limited resource, with a proposal submitted to the Borders Delivery Group for non-recurring funds to support this. In BGH, demand modelling shows that only 60% of required rehabilitation therapy is met daily, increasing risk of deconditioning and length of stay. The Committee were keen to see what impact enhancing capacity in a targeted way during acute stays would have on ongoing need on transfer of patients to the community and how this might shape the way AHP provision is provided. It is expected that there will discussions about this through the Board forums moving forward in relation to how this could be tested. The Committee took **Moderate Assurance** for governance and **Limited Assurance** for service capacity.

2.3.9 The Committee considered the annual update from the Children's Services Network. This network plays an important role in the integrated oversight of children's services and identification of system-wide risks and best practice. The Committee noted positive progress including implementation of the UNCRC Act, expanded Care Opinion Bear use across services, and delivery of the Child Poverty Action Plan. Improvements were also highlighted in CAMHS waiting times, early-intervention neurodevelopmental pathways and maternal/infant nutrition. Looking ahead, the Network will lead development of the 2026–29 plan with focus areas including transitions, trauma-informed practice, maternal/infant nutrition and psychology workforce stability. The Committee were keen to see the networks profile strengthen and to bring connection to the childrens services work and endorsed the direction of travel and confirmed **Moderate Assurance.**

2.3.10 The Committee received a report on Organ Donation and noted the service's strong governance and highly skilled multidisciplinary team. The newly mandated national Terms of Reference were endorsed without amendment. Although donor numbers remain small due to population size, performance continues to be strong, with high-quality adherence to national protocols for donor identification, family discussions, documentation and collaboration with NHS Blood and Transplant. The Specialist Nurse in Organ Donation and clinical lead maintain visible engagement across ICU, theatres

and ED. Reflecting robust governance, low risk and consistently high-quality practice, the Committee confirmed **Significant Assurance**.

2.3.11 The Committee received an update on progress against the Chief Pharmacy Standards and noted that the absence of HEPMA continues to be a significant barrier to achieving full compliance, limiting real-time medicines reconciliation, controlled-drug tracking and auditability. The Committee have previously highlighted this area to the Board for consideration within the 2026/27 financial plan as a key patient safety priority recognising the very limited capital monies which will be available to the Board. The Committee reviewed wider governance arrangements, including the need to enhance transparency of dispensing accuracy, near-miss reporting and audit frequency. The Committee welcomed the proposed structure the Director of Pharmacy has brought to reporting bringing a stronger focus to aspects of medicine management and safety and a clearer assurance focus at Board level. Given the scale of work required and structural constraints, particularly the lack of HEPMA, the Committee agreed **Limited Assurance**, recognising that leadership grip and improvement trajectory remain positive.

2.3.12 The Committee received an update on the Patient Safety Programme and welcomed significant strengthening of organisation-wide safety governance. This includes a refreshed Quality and Safety Programme Board going into 2026/27 building on the Excellence in Care steering group to bring in a wider range of Board wide clinical topics. The committee considered progress across all aspects of the local patient safety programme and welcomed progressed on the care assurance system. Workstreams are progressing well, including escalation processes for deteriorating patients, maternity and neonatal safety priorities, and embedding paediatric safety huddles. Plans to extend Care Assurance to outpatient and community teams were welcomed as essential for whole-system governance. The Committee endorsed the proposed focus for 2026/27 and agreed **Moderate Assurance**.

2.3.13 The Committee considered the Mortality Review Annual Report and noted that key indicators, including HSMR and 30-day inpatient mortality, remain stable despite an increasingly complex inpatient population. Length of stay beyond 30 days had risen significantly in the reporting period for this paper 2024/25, increasing risk of complications and deconditioning. Of 135 deaths reviewed, only two showed potential avoidable harm, with themes consistent with prior years: escalation, anticipatory care planning and documentation. ED performance was also considered, with increasing time spent in ED prior to admission reflecting broader flow pressures; ED deaths remain proportional to activity. The Committee welcomed development of a new InPhase-based mortality governance model, shifting towards continuous Team Based Quality Review. The Committee confirmed **Moderate Assurance**.

2.3.14 Patient Safety and Care Assurance

2.3.15 Hospital Mortality

NHS Borders Hospital Standardised Mortality Ratio (HSMR) for the 27th data release under the new methodology is 1.21. This figure covers the period October 2024 to September 2025 and is based on 600 observed deaths divided by 497 predicted deaths. The funnel plot in Figure 1 shows NHS Borders HSMR remains within normal

limits based on the single HSMR figure for this period therefore is not a trigger for further investigation:

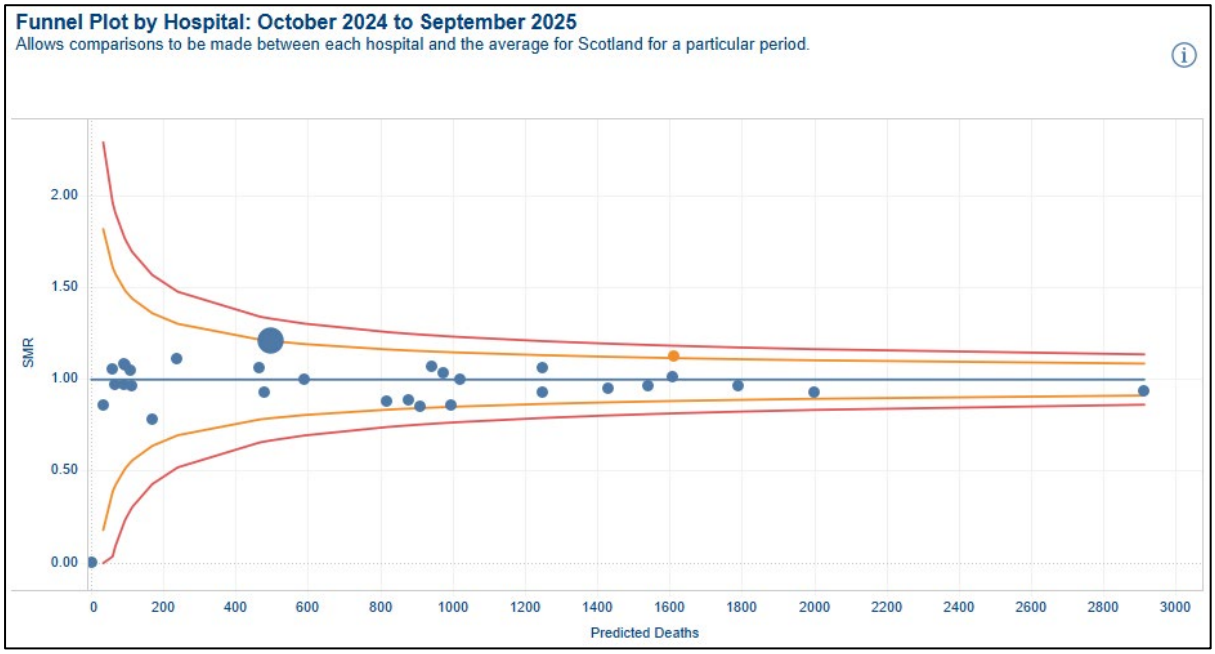


Figure 1 *Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.16 NHS Borders crude mortality rate for quarter July 2025 to September 2025 was **3.9%** and is presented in Figure 2 below:

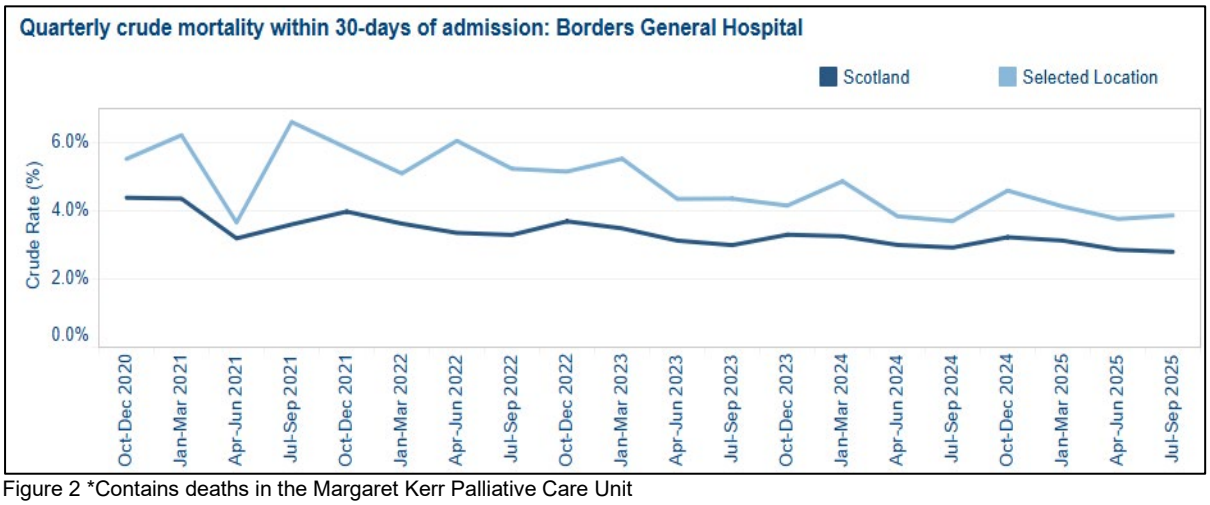


Figure 2 *Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.17 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.

2.3.18 Figure 3 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 1 February 2026:

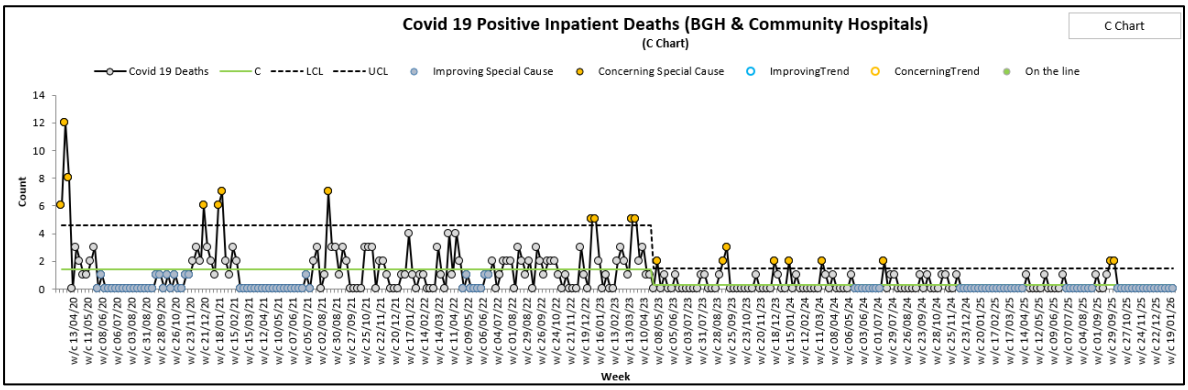


Figure 3 *From 07/05/2023 patients are counted as Covid positive for 10 days after a positive test. Prior to this, patients were counted as covid positive for 28 days after a positive test.

2.3.19 Falls

Figure 4 demonstrates the NHS Borders inpatient falls rate per 1,000 Occupied Bed Days showing normal variation. Overall, the NHS Borders falls rate remains slightly higher than the NHS Scotland average; however, it should be noted that national comparator data are not adjusted for patient age, acuity or case mix, which may influence direct comparison.

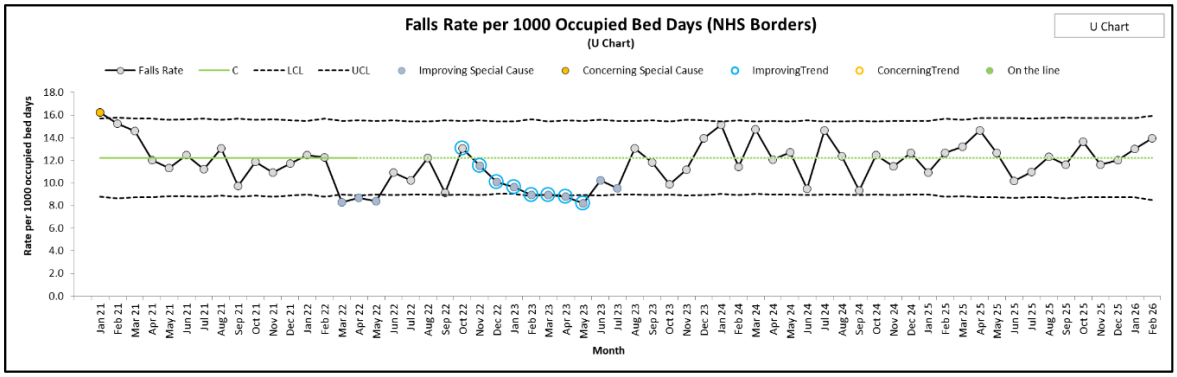


Figure 4

2.3.20 Figure 5 illustrates the NHS Borders rate of falls with harm per 1,000 OBD in adult inpatient areas. The chart demonstrates normal (common cause) variation over time, with two data periods breaching the upper control. All falls with harm are reviewed following the adverse event management policy for learning and any required action under Duty of Candour:

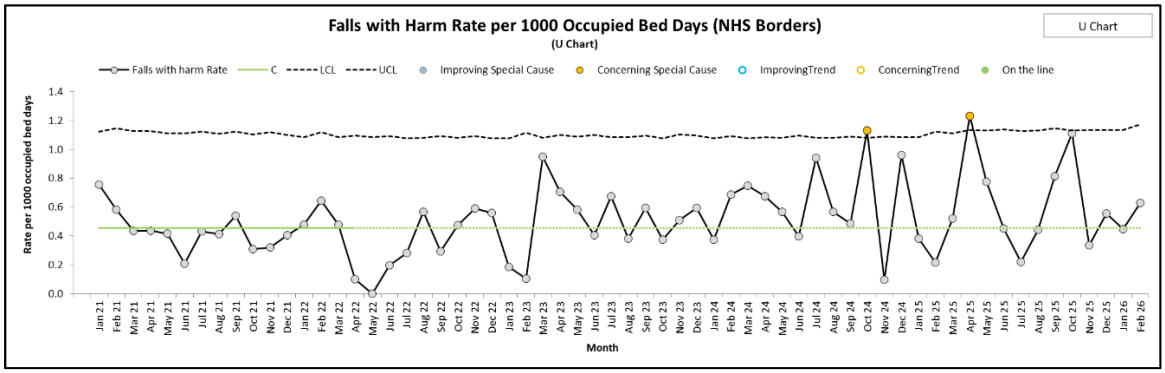


Figure 5

2.3.21 Falls prevention remains a key organisational priority, aligned with the Scottish Patient Safety Programme (SPSP) and national harm reduction expectations. The NHS

Borders Falls Strategic Group gap analysis and A3 improvement plan highlight that, while improvement activity is progressing across several inpatient areas, variation persists in the reliability of falls risk assessment, prevention and postfall management which is the focus on the group.

2.3.22 Pressure Damage

Figure 6 details the rate per 1000 OBDs of developed pressure ulcers Grade 2 and above across NHS Borders showing normal variation:

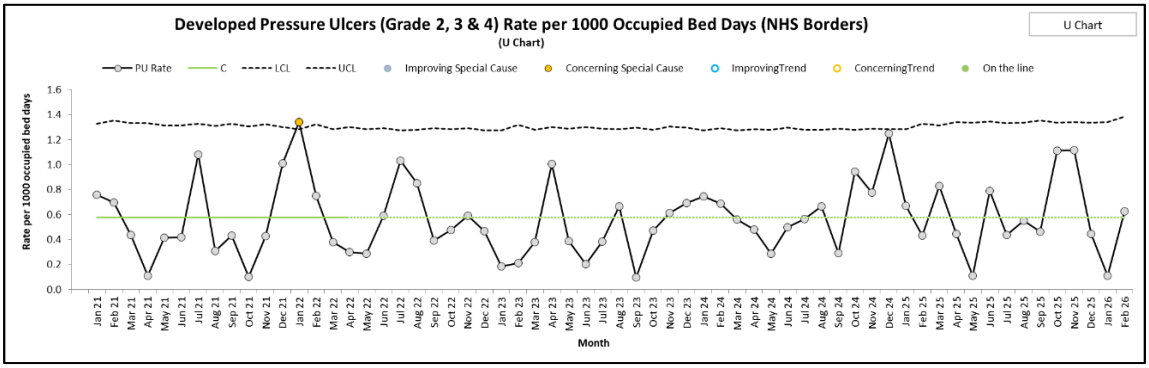


Figure 6

2.3.23 The NHS Borders Wound Assessment, Management and Escalation Flowchart has been finalised and approved for use across the Board. The flowchart provides clear, standardised guidance for staff and includes quick-link functionality to support timely access to the appropriate services for advice and escalation.

2.3.24 The pressure ulcer gap analysis and A3 improvement plan have identified shared challenges across NHS Borders, reaffirming pressure ulcer prevention as a priority for collective improvement. Targeted actions, including a review of tissue viability capacity and training provision, strengthened guidance and learning from Pressure Ulcer Investigation Tools, and information sharing across teams aim to support greater consistency, reliability and system resilience across all care settings.

2.3.25 Deteriorating Patient

Figure 7 shows normal variation in the Cardiac Arrest (CA) rate for the BGH:

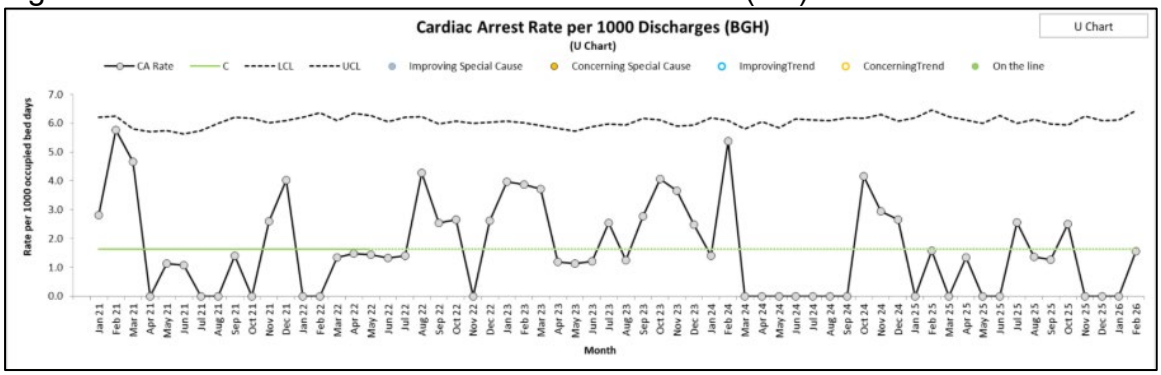


Figure 7

2.3.26 The Deteriorating Patient Workstream continues to strengthen NHS Borders' approach to the early recognition and management of clinical deterioration. Gap analysis and the A3 improvement plan has identified variation in the reliable application of early warning scores, observation practice and documentation, reinforcing the need for greater

standardisation, strengthened audit and enhanced staff education. Key priorities through 2025/26 and into 2026/27 include implementation of the updated NEWS2 chart, improved escalation training, revised documentation within Ward 17 and the Emergency Department, and ongoing work to embed Treatment Escalation Planning, sepsis recognition and DNACPR communication.

2.3.27 EiC Quality of Care (QoC) Review Guidance provides a “Once for Scotland” approach to quality-of care reviews and care assurance visits and helps to support care assurance processes at a local level. NHS Borders’ Care Assurance Delivery Programme has been developed in partnership with national guidance and approved by the Borders Delivery Group (BDG).

2.3.28 Implementation of the process has been embedded across BGH acute inpatient areas and women’s and children's inpatient services. A framework is available that provides information based on the guidance, roles and responsibilities, escalation and governance.

2.3.29 Spread of the programme has begun within inpatient Mental Health areas, and scoping has begun with the Community Midwifery team. Further support is required to embed the process throughout BGH, community hospitals, community nursing and AHP teams.

2.3.30 NHS Borders Ward Quality Audit Programme is currently under review with support from key stakeholders identified through the EiC Steering Group, measures for all workstreams will be refreshed, in line with recent gap analyses and national standards.

2.3.31 The fifth QoC review under the new methodology has been commissioned by the Associate Director of Nursing for Acute Services, the multi-professional CAV is scheduled to take place in the Emergency Department (ED) on 14 March 2026.

2.3.32 The Daily Care Plan (DCP) Quality Improvement project is being undertaken in Ward 4 with the aim of reducing avoidable developed pressure ulcers by 50% by June 2026. The project commenced on 1 December 2025. The DCP was originally tested within the Medical Assessment Unit (MAU) and, following review and approval by the NHS Borders Excellence in Care Steering Group, progressed to downstream testing, with Ward 4 volunteering to support this phase of the work.

2.3.33 The DCP supports a simplified, person centred approach to care planning, reducing duplication while strengthening the visibility of risk, assessment and planned care. Early data from December 2025 and January 2026 indicate that Ward 4 reported no developed pressure ulcers during this period. Pressure ulcer data have been validated locally and require updating within the Senior Charge Nurse dashboard. While this represents an early signal of improvement, ongoing monitoring, learning and staff education will continue as the project progresses towards the June 2026 aim.

2.3.34 Patient Experience

2.3.35 Care Opinion

For the period 1 April 2025 to 16 March 2026 172 new stories were posted about NHS Borders on Care Opinion. Figures 8 and 9 below show the number of stories told in

that period and their criticality. As of 16 March 2026, the stories had been viewed 21,528 times:

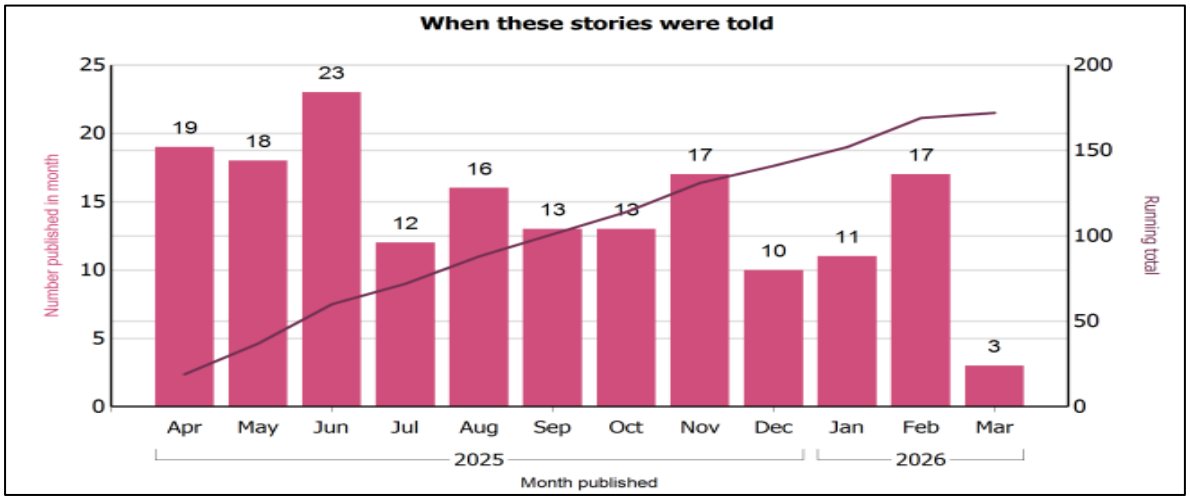


Figure 8

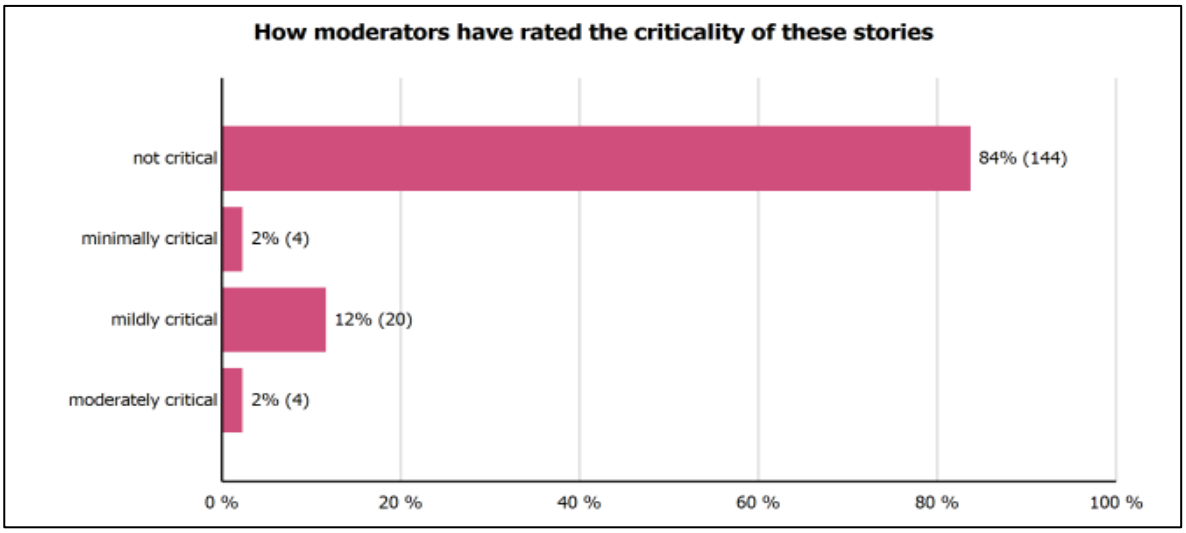


Figure 9

2.3.36 Figure 10 below displays 2 of the most popular stories, out of all the stories included in this report:

The most thorough and accurate test - 843 views

Posted by **Lauder** as the patient 4 weeks ago

I am 86 years of age. I had a hearing test recently at the Audiology Dept of the Borders General Hospital, Melrose. I was seen there by Audiologist Alastair.

He gave me the most thorough and accurate test. As a result I was fitted with two new hearing aids. (Previous ones were 10 years old). The new ones have changed my life! My hearing is now excellent!! Hearing sounds etc I have not heard in years.

The attention, help and understanding I...

I couldn't have asked for anything more - 567 views

Posted by **Josxc47** as a service user 3 weeks ago

Just want to send my gratitude to the staff in the maternity ward, especially thanks to Allison maternity healthcare assistant, Carly and Joan midwifes in ward 16 for looking after me the last couple of days in the ward.

You guys have gone above and beyond and being on the other side this time as a patient I couldn't have asked for anything more

Figure 10

2.3.37 To support understanding at a glance, we have summarised below in Figure 11 the key themes, previously shared as a word cloud, highlighting both *What's Good* and *What Could Be Improved*. We have also included the '*Feelings*' expressed by posters to provide additional context and insight:

Most common tags added by authors to these stories

What's good?		*What could be improved?*		*Feelings*	
staff	80	communication	14	Thankful	40
Care	54	information	4	supported	29
kindness	31	access to service	3	reassured	26
compassion	26	lack of support	3	grateful	24
friendly	26	more staff	3	cared for	23
midwives	25	staffing levels	3	safe	23
professional	24	waiting times	3	comfortable	21
amazing	23	delays	2	well looked after	15
caring	21	discharge	2	listened to	14
above and beyond	20	Discharge process	2	respected	13
communication	20	follow up	2		
level of care	20	follow-up	2		
		More funding	2		
		Patient Communications	2		
		Staffing	2		
		wait time	2		
		waiting time	2		

Figure 11

2.3.38 Complaints

Figure 12 below shows the number of formal complaints received by month from January 2020 to February 2026.

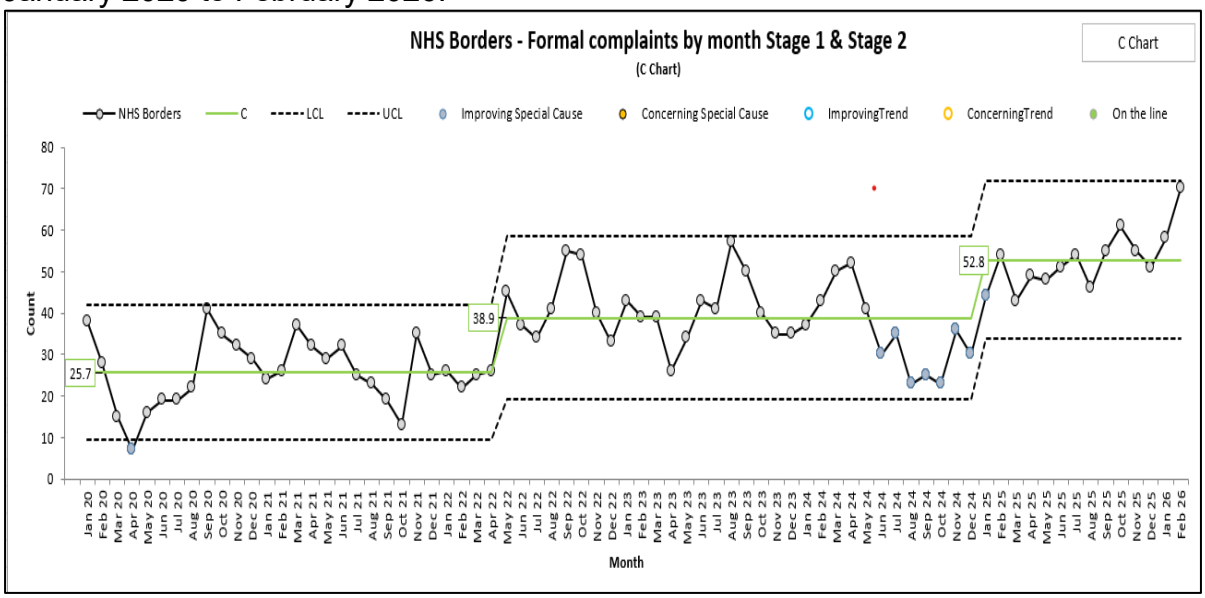


Figure 12

2.3.39 Complaint volumes have continued to rise reflecting ongoing pressure on key services.

2.3.40 To further support the investigation and timely response to complaints and additional team member has joined the Patient Experience Team (PET) from February 2026 on a

fixed term basis. The additional resources aims to support the increasing demand and our aim to respond more consistently to both Stage 1 and Stage 2 complaints within the required national timeframes.

2.3.41 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 from January 2020 to February 2026:

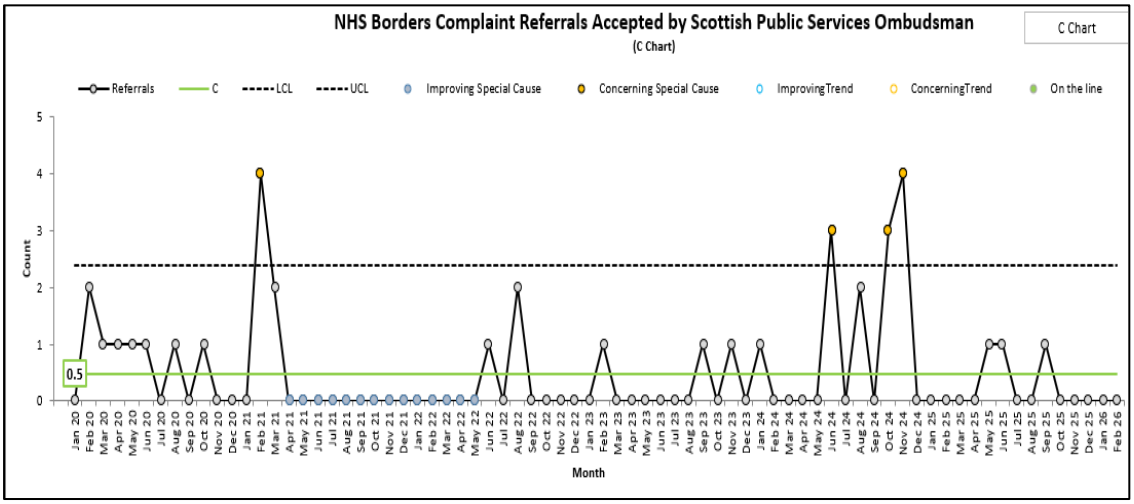


Figure 13

2.3.42 Over the last 12 months (February 2025 to February 2026), the SPSO has upheld one complaint. During the same period, there has been a notable decline in the number of referrals accepted for investigation by the SPSO.

2.3.43 Where a complainant expresses dissatisfaction with their response, the PET often re-engages with the service to gather further information, offer clarification, or arrange a meeting. When the SPSO does receive contact from a complainant, they review the responses already provided. In many cases, they acknowledge that learning has been identified and conclude that there is nothing further to be gained by asking the Board to undertake additional investigation. There has been positive feedback provided on the follow up process provided by PET but recognition of the additional workload this has introduced.

2.3.44 COVID Inquiries update

NHS Borders continues to participate in the Scottish Covid-19 Inquiry along with all other Boards in NHS Scotland. Hearings examining how Scottish Government policies and guidance were implemented during the pandemic will take place between 5 and 23 October 2026.

2.3.45 The Scottish Covid-19 Inquiry will release five Narrative Records covering the COVID-19 pandemic's impact on:

- Health and social care
- Education and certification
- Businesses and the self-employed
- Welfare assistance programmes
- Justice, equalities and human rights, worship and life events

2.3.46 The first Narrative Record, covering health and social care is due to be published during March 2026. This record will summarise evidence from over 16 weeks of public hearings. In addition, Let's Be Heard, the Scottish Covid-19 Inquiry's public protection project, will also publish four volumes of evidence reflecting the experiences of those who contributed to the project.

2.3.47 Hearings are available on the Scottish Covid-19 Inquiry's YouTube channel: https://www.youtube.com/@covidinquirysco.

2.3.48 NHS Borders also participates in the UK Covid-19 Inquiry along with all other Boards in NHS Scotland. The final hearing of the UK Covid-19 Inquiry's Module 10 investigation, covering the impact of the pandemic on society, was held on 5 March 2026. The UK Covid-19 Inquiry published the last of its 10 Every Story Matters records on 5 March 2026.

2.3.49 The UK Covid-19 Inquiry is scheduled to publish the following reports and recommendations:

- 19 March 2026 - Module 3 'Healthcare Systems'
- 16 April 2026 Module 4 'Vaccines and Therapeutics'

2.3.50 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.

2.3.51 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 redesign 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.

2.3.52 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.

2.3.53 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.

2.3.54 Equality and Diversity, including health inequalities
An equality impact assessment has not been undertaken for the purposes of this awareness report.

2.3.55 Climate Change
No additional points to note.

2.3.56 Other impacts
No additional points to note.

2.3.57 Communication, involvement, engagement and consultation
This paper is for awareness and assurance purposes and has not followed any consultation or engagement process.

2.3.58 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, an overall a level of **moderate assurance** is proposed based on the mixed assurance levels taken at Board Clinical Governance Committee.

3 Glossary

AHP	Allied Health Professions
BDG	Borders Delivery Group
BGH	Borders General Hospital
CA	Cardiac Arrest
CAMHS	Child and Adolescent Mental Health Service
CAV	Care Assurance Visits
CGC	Clinical Governance Committee
CNM	Clinical Nurse Manager
DCP	Daily Care Plans
ED	Emergency Department
EiC	Excellence in Care
ERHPS	East Region Health Protection Services
HEPMA	Hospital Electronic Prescribing and Medicines Administration
HSMR	Hospital Standardised Mortality Ratio
ICU	Intensive Care Unit
LD	Learning Disabilities

NEWS2	National Early Warning Score 2
OBD	Occupied Bed Days
PCS	Primary and Community Services
PET	Patient Experience Team
QoC	Quality of Care
SPSO	Scottish Public Services Ombudsman

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Infection Prevention and Control**
Responsible Executive/Non-Executive:	**Director of Nursing, Midwifery & AHPs**
Report Author:	**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 Scottish Government requires reports on infection surveillance and monitoring of key topic areas impacting on the prevention and control of infection to be discussed as part of bi - monthly Board meetings and published on NHS Board websites.

2.3 Assessment

Contents

1.0 Executive Summary

1.1 This report provides the NHS Borders Board with an update on Infection Prevention and Control (IPC) performance for February 2026, with particular focus on healthcare associated infections (HAI), compliance with national standards, and progress against Scottish Government targets. The report supports assurance on patient safety and organisational performance and aligns with the NHS Scotland quality ambition of delivering safe care.

1.2 Surveillance data show no statistically significant change in healthcare associated Clostridioides difficile infection (CDI) or Escherichia coli bacteraemia (ECB) since the previous reporting period, and NHS Borders remains on trajectory to meet the 2025/26 national standards for both infections. In contrast, Staphylococcus aureus bacteraemia (SAB) remains above the national trajectory, with recent cases predominantly associated with urinary catheters, peripheral venous catheters, and skin and soft tissue sources. Targeted actions to reduce SAB risk continue, including strengthened catheter and PVC practice and ongoing MRSA screening.

1.3 Process measures demonstrate generally strong performance in cleaning standards and audit outcomes, with the majority of audited areas achieving green ratings and compliance comparable to national performance. Mandatory training compliance shows improvement, although variation remains, particularly in hand hygiene training uptake. Quality improvement activity continues across key risk areas, including CAUTI, PVC safety, hand hygiene, and standardised cleaning documentation, with several initiatives progressing through testing and implementation phases. Overall, the report provides **moderate assurance** that IPC arrangements are effective, with focused improvement activity in place to address identified risks.

2.0 Outcome Measures - Infection Surveillance

2.1 *Clostridioides difficile* infection (CDI) - Key Messages

- There has not been any statistically significant change in healthcare associated (HAI) CDI cases since the last report (**Figure 1**)
- NHS Borders is on trajectory to meet the new Scottish Government HAI CDI standard for 2025/26 (**Figure 2**)
- Measures to reduce the risk of CDI:
  - Antimicrobial stewardship - reduce and control use of antibiotics that are more strongly associated with causing CDI (oversight provided by the Antimicrobial Management Team)
  - Good Hand Hygiene practice **(Section 3.1)**
  - Good standard of environmental and equipment cleaning **(Section 3.2** and **Section 3.3)**
- Background information and explanation is provided in **Appendix A, B and C**

2.2 *Escherichia coli* bacteraemia (ECB) - Key Messages

- There has not been any statistically significant change in the number of HAI ECB cases since the last report (**Figure 3**)
- NHS Borders is on trajectory to meet the new HAI ECB standard for 2025/26 (**Figure 4**)
- Lower Urinary Tract Infection (UTI) and Urinary catheters are the primary cause of ECB infections (**Figure 5**)
- Measures to reduce the risk of ECB:
  - Recent cases of UTI associated ECB will be reviewed to see if any learning for improvement is identified
  - Avoid using urinary catheters when possible, maintain urinary catheters in accordance with NHS Borders Policy, remove urinary catheters at the earliest opportunity (**Section 5.1**)

Background information and explanation is provided in **Appendix A, B and C**

2.3 *Staphylococcus aureus* Bacteraemia (SAB) - Key Messages

- There has not been any statistically significant change in the number of HAI SAB cases since the last report (**Figure 6**)
- NHS Borders is not on target to achieve the new HAI SAB standard in 2025/26 (**Figure 7**)
- The main known recent causes of healthcare associated SAB cases were skin / soft tissue, urinary catheters and Peripheral Venous Catheters (PVC) (**Figure 8**)
- Measures to reduce the risk of SAB:
  - Avoid using urinary catheters when possible, insert and maintain in accordance with NHS Borders Policy, remove at the earliest opportunity (**Section 5.1**)
  - Avoid using PVCs when possible, insert and maintain in accordance with NHS Borders guidance, remove at the earliest opportunity (**Section 5.2**)
  - Adult inpatients (excluding Mental Health and Maternity) should be screened for Methicillin-resistant *Staphylococcus aureus* (MRSA) (**Section 3.5**)

Background information and explanation is provided in **Appendix A, B and C**

2.4 Surgical Site Infection (SSI) Surveillance

- 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.
- Up to date orthopaedic SSI surveillance is not currently available whilst reviews of historic cases are progressing. A meeting is scheduled in March 2026 to commence a deep-dive review of suspected SSI cases in 2025
- SSI Surveillance data for c-sections will now be included in reports. There has not been any statistically change in the SSI rate for c-sections **(Figure 9)**

2.5 National Records of Scotland Death Data

- National Records of Scotland (NRS) produce weekly death data reports which are reviewed and collated monthly
- The Scottish Government requires regular reporting of NRS death data for C. difficile and MRSA to the Infection Control Manager (SGHD/CMO 2011/13)
- **Figure 10** shows the number of deaths per month where *C.difficile, E.coli* or *S. aureus* (including MRSA) was noted on the death certificate and the person's primary place of residence at time of death was within the Scottish Borders. This data is based on specific codes in the data to indicate these infections. The graph should be interpreted with caution due to variation in the recording of infection on death certificates by doctors and the potential for human error in subsequent coding attributed to the narrative on the certificate.

3.0 Process Measures

3.1 Hand Hygiene – Key Messages

- The process for auditing and report hand hygiene compliance is currently under review (see item 5.3)

3.2 Cleaning – Key Messages

- Cleanliness is monitored in accordance with national standards
- There is a national target to maintain overall compliance with standards above 90%
- **Figure 11** shows that of the areas audited, all audited areas scored above the standard 90% in January
- In **Figure 11** 'Domestic' reporting refers to the environmental cleanliness of surfaces cleaned by domestics. 'Estates' reporting refers to issues with the fabric of the building which impede effective cleaning
- Any area that does not reach this standard should have the issues rectified and the area re-audited within 21 days
- NHS Borders compliance is comparable with NHS Scotland (**Figure 12**)

3.3 Audit – Key Messages

- With one exception, all management actions in response to the 2024 infection control internal audit report have been completed (**Figure 13**). The outstanding action due for completion 31/12/2025 is to develop and implement standardised cleaning documentation in inpatient areas in BGH. This action has been largely completed with just two areas remaining to implement the documentation. Both of these areas are on target to implement the documentation by 31/03/2026
- Between December and January, 7 full infection control audits were completed with 6 areas achieving a 'Green' status and 1 area an 'Amber' status
- Between December and January, 23 spot checks were completed resulting in 1 area achieving a 'Red' status 3 areas achieving an 'Amber' status with the remaining achieving a 'Green' status with a score of 90% or higher
- Recurring themes from the audits and spot checks:

Recurring themes of good practice

- Good PPE practice
- Hand gel dispensers clean and working
- Waste managed correctly

Recurring themes of poor practice

- Single patient use items in communal items
- Dirty commodes
- Temporary closures on sharps bins not in use

- Senior Charge Nurses are provided with verbal and written feedback to share with their teams
- General Services management are copied into feedback to address environmental cleaning issues
- New cleaning documentation has been implemented in most inpatient areas in BGH. Spread to other areas will progress in 2026
- Themes from spot checks and audits are used to inform content of staff education delivered by the Infection Prevention and Control Team

3.4 Care Home visits

- The Infection Prevention and Control Team provide support to care homes in the Scottish Borders. A care home audit tool is used to ensure consistency in approach and to support an objective assessment with a 'Red', 'Amber' or 'Green' (RAG) status to inform further action.
- In December and January, 5 care homes were visited with 1 scoring 'Red', 1 scoring 'Amber' and 3 scoring 'Green'.

3.5 HAI Risk – Inpatient Admission Screening

- MRSA screening of adult inpatients (excluding Maternity and Mental Health services) is mandatory in Scotland (DL 2019 23)
- MRSA admission screening compliance is monitored monthly for the four main admitting wards within BGH. Compliance in February 2026 was 85% (**Figure 14**)
- Carbapenemase-producing enterobacteriaceae (CPE) inpatient screening is mandatory in Scotland (DL 2019 23)
- CPE admission screening compliance is monitored monthly for the four main admitting wards within BGH. Compliance in February 2026 was 75% (**Figure 15**)
- In Quarter 3 2025, NHS Borders had a higher level of compliance with MRSA and CPE screening than NHS Scotland (**Figure 16**)
- Monthly compliance reports are fed back to the Senior Charge Nurse and Clinical Nurse Manager for the relevant wards

3.6 Mandatory Training

- On 1st February 2026, NHS Borders overall staff training compliance was:
  - Infection Control – Core Mandatory E-Learning Module (all substantive staff) 81.4%.
  - NES Hand Hygiene – Role Mandatory E-Learning Module (all relevant substantive staff) 37.60%. This is an increase of 1.30% since last report.

3.7 Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI-SCRIBE)

- NHS Borders follows national guidance (SHFN 30) to control the risks associated with building works. The process requires a risk assessment to guide proportionate control measures. The risk assessment considers the type of works being undertaken (**Figure 17**) and the risk to patients (**Figure 18**) to determine the class of precautions to be implemented (**Figure 19**).
- HAI-SCRIBE applies to all relevant stages of each project with detailed steps to consider risks associated with the planned location, design and specification along with the infection risks arising from the building works:
  - Stage 1: Initial brief and proposed site for development
  - Stage 2: Design and planning
  - Stage 3: Construction and refurbishment work
  - Stage 4: Review of completed project
- The Infection Prevention and Control Team are currently supporting the following live Estates projects:

Estates Project	Estates Activity	Patient Risk	Classification of Precautions
BGH Bus stop	Type 3	Highest	Class III / IV
RAAC assessment / mitigation (Kelso)	Type 3	High	Class III / IV
RAAC assessment / mitigation (Duns)	Type 3	High	Class III / IV
Laboratories reconfiguration for replacement equipment (BGH)	Type 3	High	Class III / IV
Aseptic suite, BGH	Type 3	High	Class III / IV
Flooring replacement (Hawick)	Type 3	High	Class III / IV
BMC - water system	Type 4	High	Class III / IV
Flooring replacement (Labour)	Type 2	High	Class II
Flooring replacement (SCBU)	Type 2	Highest	Class III / IV
Lift refurbisment / replacment (BGH)	Type 2	Highest	Class III / IV
Flooring replacement (Radiology)	Type 2	High	Class II
Hawick GP walk-in service	Type 3	High	Class III / IV
Dialysis - single room water ingress	Type 3	Highest	Class III / IV
Ward 7 - water ingress	Type 2	High	Class III / IV
Ward 9 - refurb shower room (bay 2)	Type 3	High	Class III / IV

4.0 Adverse Events / Outbreaks / Incidents

4.1 Adverse Events

- The Infection Prevention and Control Team reviews all infection control incidents reported via InPhase and provide topic specialist advice when appropriate
- During January 2026, there was 1 minor incident and 1 moderate incident

4.2 Outbreaks – Key Messages

- Since the last update, there have been 16 closures in NHS Borders. Detail of each closure is reported under **Figure 20**.

5.0 Quality Improvement

5.1 Prevention of Catheter Associated Urinary Tract Infection (CAUTI)

- The Prevention of CAUTI Group continues to oversee actions to reduce the risk of CAUTI. Following the most recent meeting, Infection Prevention & Control (IPC) will be leading process mapping workshops for acute, community hospitals, district nursing and care homes.
- The Chair of the Group will also explore including catheter care in the Excellence in Care (EiC) Programme.
- The CAUTI Task and Finish Group continues to progress with their specific remit:
    - Develop new urinary catheter documentation to replace the existing Catheter Passport used by staff in the acute setting
    - Develop or recommend a patient information leaflet to support safe catheter use and self-care
    - Review and update NHS Borders Urinary Catheterisation Policy to ensure alignment with current best practice
- The Task and Finish Group has developed a catheter insertion and change sticker, daily maintenance bundle and a discharge checklist to support continuity of care.
- Testing of the new documentation began on a ward in BGH December 2025. Initial engagement was slow due to staffing and site pressures, however engagement has since improved. The pilot is currently in the “Study” phase of the PDSA cycle. Staff are currently using the documentation during catheter insertion and maintenance. Feedback collected so far suggests improved clarity and consistency compared with the previous Catheter Passport. Emerging issues, mainly relating to layout and wording, are being addressed for refinement prior to wider testing.
- The Task & Finish Group are exploring utilisation of Trakcare to see if content regarding catheters can auto populate onto discharge letters.
- Infection Prevention & Control (IPC) will attend two planned education sessions to support ward staff and highlight the ongoing testing of the documentation. IPC are also working closely with the Clinical Educators to ensure consistent education is delivered.

5.2 Peripheral Venous Catheter (PVC)

- The project aims to improve the safety and quality of peripheral vascular catheter (PVC) use across acute inpatient areas by:
    - Standardising documentation and improving access
    - Improving staff knowledge
    - Strengthening audit processes

- Current EiC audits show variable completion of PVC insertion and maintenance records. This increases patient risk of phlebitis, avoidable cannulation attempts, and healthcare-associated infections (HAI).
- IPC will provide regular progress updates through the EiC governance structure to ensure oversight.

5.3 Hand Hygiene

- An SBAR was submitted to the Infection Control Committee (ICC) in January 2026 requesting support for IPC to review the current hand hygiene audit process
- The existing process provides robust data but does not support cultural change or leadership accountability consistently
- Recent staffing challenges and service pressures have impacted on ward level capacity to engage with and/or sustain quality improvement activity. Without quality improvement activity between audit rounds, the value of repeated audits is uncertain.
- A small working group is to be convened to examine how audits are conducted and reported, assess opportunities to shift the focus from aggregated compliance results toward ward-level ownership, leadership accountability, and meaningful quality improvement
- A revised approach will be recommended to the next meeting of the Infection Control Committee for approval

5.4 Cleaning Standards

- Standardised cleaning documentation was developed in response to the 2024 Infection Prevention & Control Internal Audit Report which found inconsistent completion of cleaning records, limited transparency and variation in cleaning practices.
- The comprehensive cleaning standards outlines:
  - Responsibilities
  - Cleaning requirements between patients
  - Discharge/transfer checklists
  - Daily cleaning schedules
  - Rapid assurance tool for senior nursing staff
  - Domestic duties record sheets
- Spread of new standardised cleaning documentation is progressing well across inpatient areas. Regular visits are carried out by IPC to assess how well the new process is embedding. Given recent staffing and service pressures, variability in daily schedule completion has been identified and highlighted to senior nursing staff.
- Completion of documentation has been included into the IPC audit and spot check process for monitoring and assurance.

- The next steps are to test this documentation in community hospital and mental health and develop similar documentation for testing and developing in outpatient areas.

6.0 Horizon Scanning

- No national alerts published since the last update report

7.0 National Guidance/Learning

7.1 Policy/guidance updates

- HAI Quarterly Report Q3 2025 - Full Report

7.2 Healthcare Improvement Scotland (HIS) Report Findings for noting

- Western Isles Hospital – Unannounced follow up inspection report October 2025 – Healthcare Improvement Scotland
- Glasgow-Royal-Hospital-for-Children-Ward-4-safe-delivery-of-care-inspection-report-January-2026.pdf

2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety

2.3.2 Workforce

This assessment has not identified any workforce implications.

2.3.3 Financial

This assessment has not identified any resource implications.

2.3.4 Risk Assessment/Management

All risks are highlighted within the paper.

2.3.5 Equality and Diversity, including health inequalities

This is an update paper, so a full impact assessment is not required.

2.3.6 Climate Change

None identified

2.3.7 Other impacts

None identified

2.3.8 Communication, involvement, engagement and consultation

This is a regular update as required by SGHD and has not been subject to any prior consultation or engagement although much of the data is included in the monthly infection control reports which are presented to divisional clinical governance groups and the Infection Control Committee.

2.3.9 Route to the Meeting

This report has not been submitted to any prior groups or committees but much of the content 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/Committee 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, Graphs and Tables
- Appendix B, Background Explanation
- Appendix C, Graphs and Data Explanation

Appendix A

Figure 1

NHS Borders, days between healthcare associated CDI cases (G Chart). May 2023 - January 2026

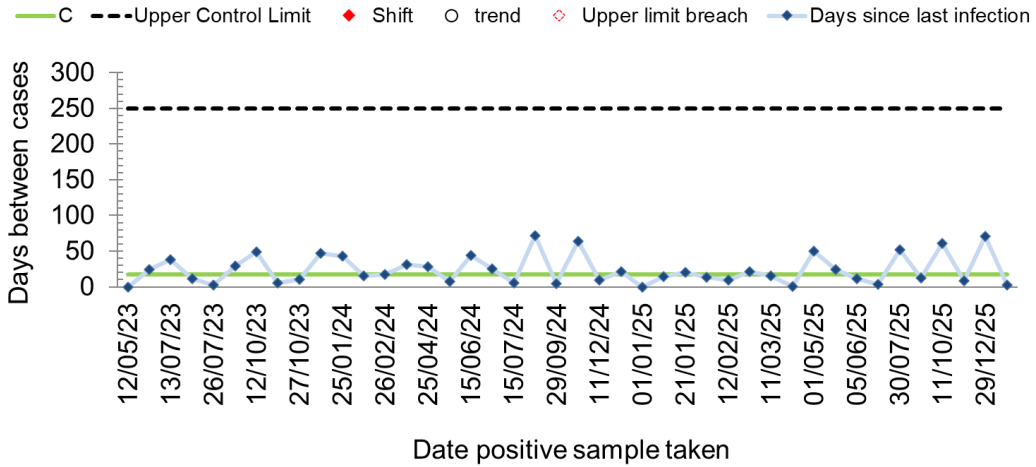


Figure 2

NHS Borders cumulative healthcare associated CDI cases Vs Scottish Government target trajectory (April 2025 - March 2026)

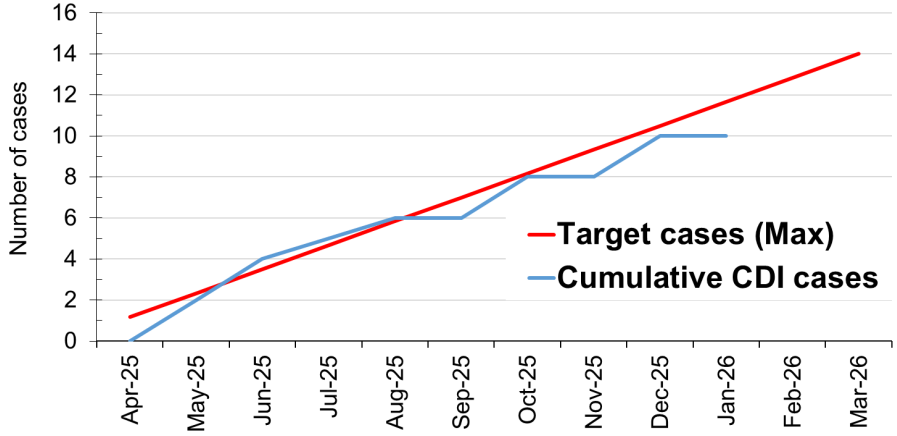


Figure 3

NHS Borders healthcare associated ECB cases per month (C Chart). January 2023 - January 2026

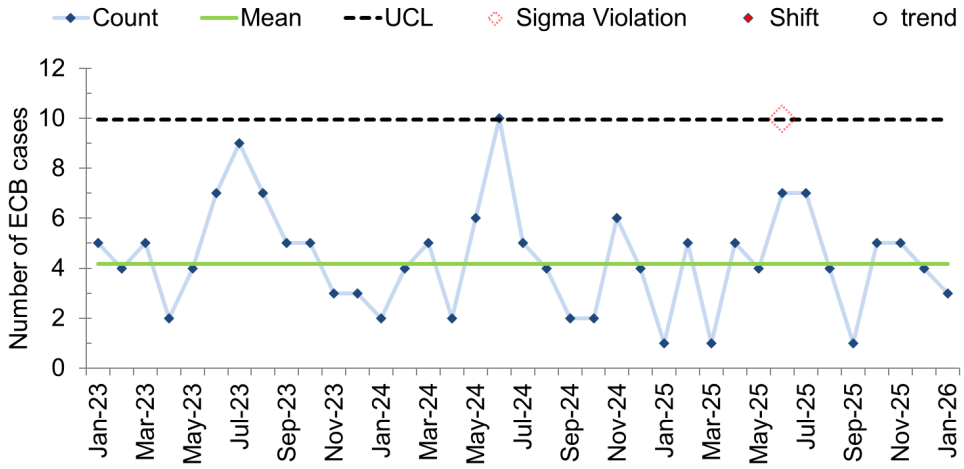


Figure 4

NHS Borders cumulative healthcare associated ECB cases Vs Scottish Government target trajectory (April 2025 - March 2026)

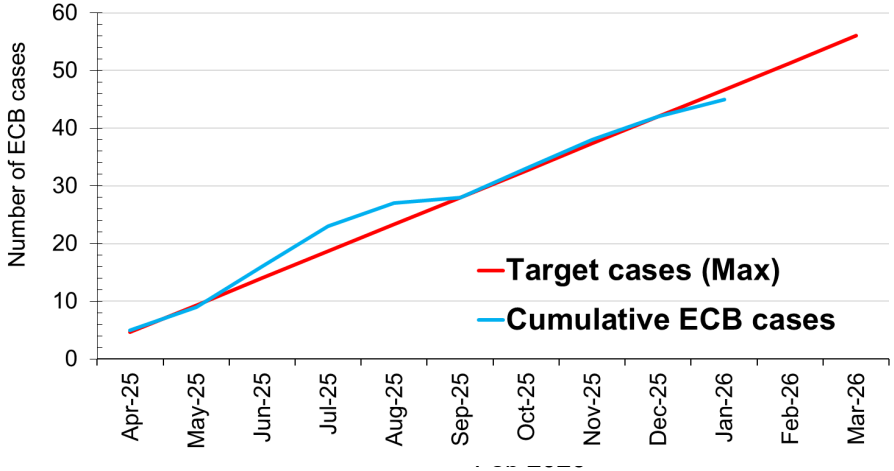


Figure 5

Pareto Chart of healthcare associated ECB cases by source of infection
Rolling 12 months Feb 2025 - Jan 2026

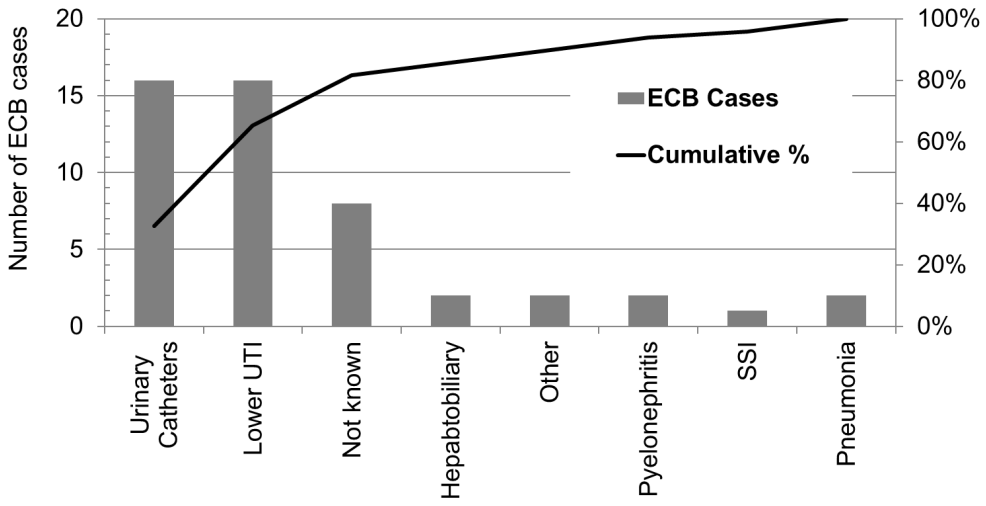


Figure 6

NHS Borders, days between healthcare associated SAB cases (G Chart). February 2024 - January 2026

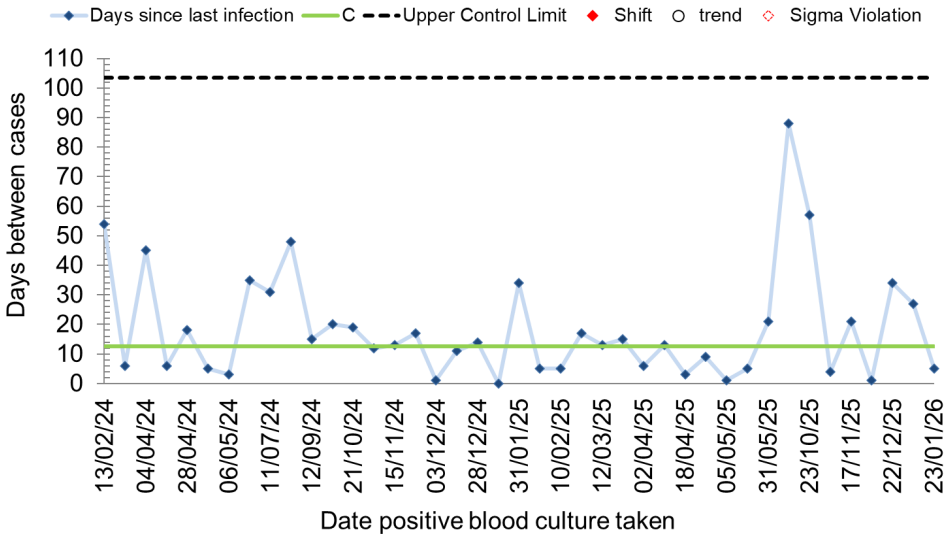


Figure 7

NHS Borders cumulative healthcare associated SAB cases Vs Scottish Government target trajectory (April 2025 - March 2026)

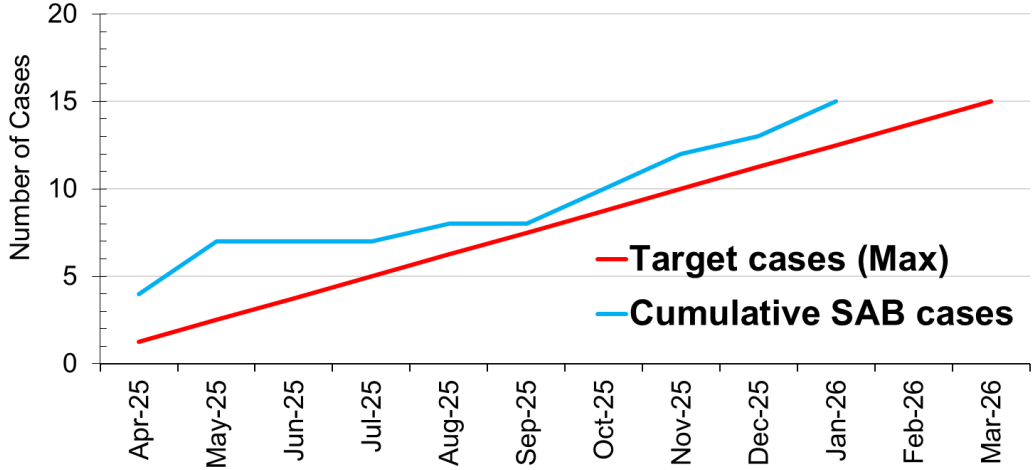


Figure 8

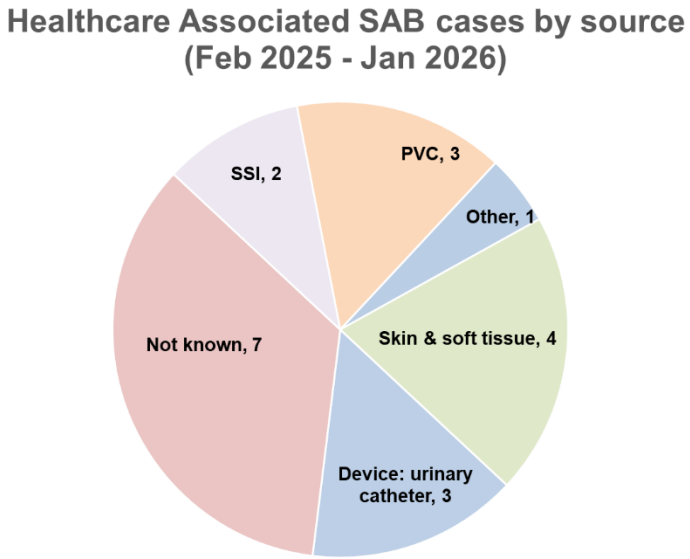


Figure 9

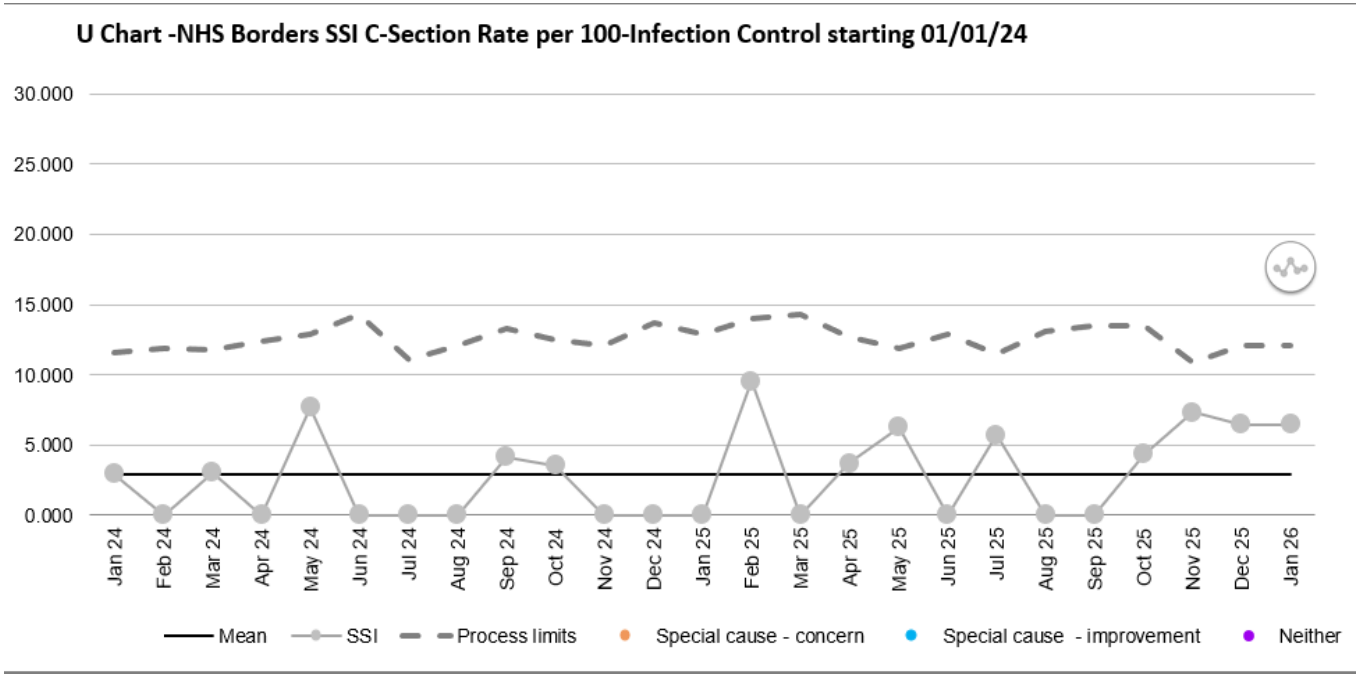


Figure 10

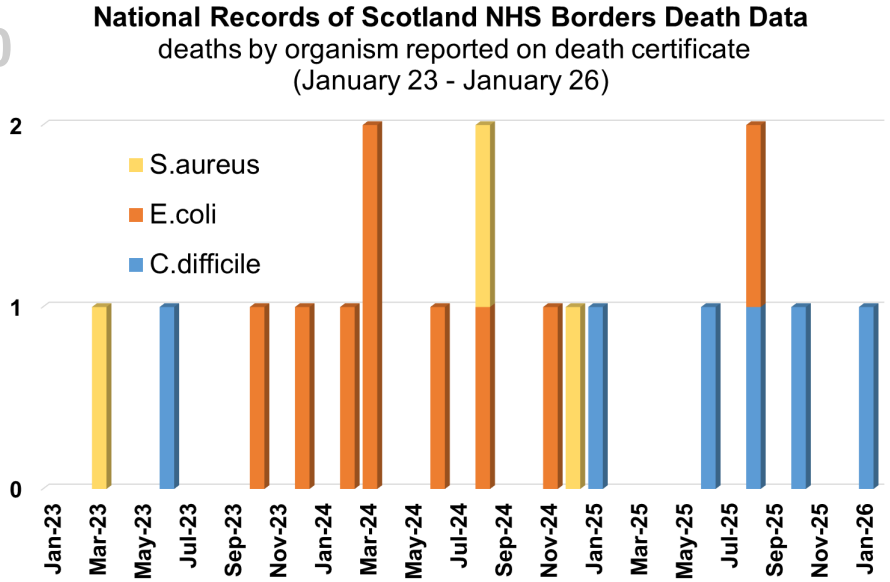


Figure 11

Ward	2025				2026	
	Nov		Dec		Jan	
	Domestic	Estates	Domestic	Estates	Domestic	Estates
Ward 4	93.3	95.0	95.1	94.8	92.9	99.1
Ward 5	93.8	100.0	97.7	90.9	94.2	97.3
Medical Assessment Unit	93.1	98.1	94.0	92.7	93.5	98.8
DME14	94.8	100.0	97.0	100.0	95.3	92.3
Emergency Department	89.6	96.8	93.0	96.5	90.9	96.5
MKU	96.8	93.9	97.8	98.7	94.9	91.4
BSU	95.8	100.0			97.3	96.8
Renal Dialysis	96.2	100.0	97.9	98.6	98.7	100.0
Ward 7	83.6	97.4	93.0	93.8	90.7	98.8
Ward 9	94.2	100.0	94.1	100.0	95.7	100.0
ITU	98.8	99.3			97.3	98.7
DPU	96.9	95.5	97.5	95.4	94.3	92.2
Ward 17	96.1	100.0	96.3	100.0	92.6	100.0
Borders Macmillan Centre	95.7	94.2	96.7	97.0	97.4	97.8
Theatre	96.1	100.0	94.6	97.1		
Endoscopy	95.5	94.8	94.8	95.1	95.0	95.7
Ward 15	92.8	92.4			97.8	97.4
Ward 16	94.0	96.7			92.2	98.8
Labour/SCBU	93.8	90.5	95.3	100.0	94.6	100.0
	Estates		Domestic	Estates	Domestic	Estates
Haylodge Hospital (Ward 1)						
Hawick Hospital (Ground Floor Ward Area)	100.0					
Kelso Hospital (Ward 2)	99.3				94.4	99.1
Knoll Hospital (Ward Area)						
East Brig (Galavale)	95.9				98.7	100.0
Huntlyburn Ground Floor Ward	94.6				96.9	94.7
Borders Specialist Care Dementia Unit						
Cauldshiels	100.0				95.9	98.8
	Estates		Domestic	Estates	Domestic	Estates
New OPD	100.0		91.5	100.0		
BUCC						
OPD First Floor	100.0		87.9	100.0		
Eye Centre			97.9	100.0		
Coldstream Dental Unit						
Hawick Dental Unit						

Figure 12

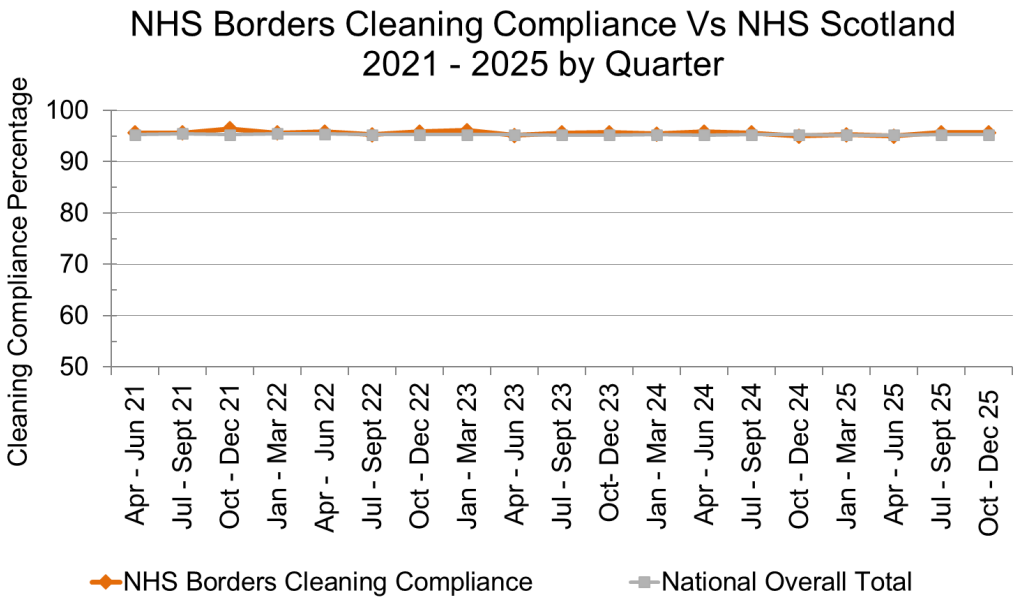


Figure 13

2024 Internal Audit - Infection Prevention &Control Action

Progress as at 30/12/2025

		Status
1	**Develop and implement standardised cleaning documentation for patient equipment in inpatient areas.** Responsible Officer: Clinical Nurse Managers Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/12/2025	In progress
2	**Review IPCT audit tool to include assessment of compliance with completion of cleaning records.** Responsible Officer: Infection Control Manager Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/03/2025	Complete
3	**Include IPC audit programme in annual Infection Control Workplan.** Responsible Officer: Infection Control Manager Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/03/2025	Complete
4	**Implement daily IPC review across inpatient wards using the Rapid Assessment Tool Review.** Responsible Officer: Clinical Nurse Managers Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/03/2025	Complete
5	**Clinical Nurse Managers to routinely review completion of Rapid Assessment Tool and improvement activity to address issues.** Responsible Officer: Clinical Nurse Managers Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/05/2025	Complete
6	**Update Hospital Safety Brief script to include Facilities issues.** Responsible Officer: Quality Improvement Facilitator Executive Lead: Interim Director of Acute Services Due Date: 31/12/2024	Complete
7	**Senior Charge Nurses to formalise communication with staff about audit outcomes and improvement activity.** Responsible Officer: Clinical Nurse Managers Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/05/2025	**Complete**
8	**Infection Control Manager to attend the Senior Charge Nurse Forum to discuss promotion of improvement activity.** Responsible Officer: Infection Control Manager Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/05/2025	**Complete**
9	**Promote completion of the NES hand hygiene module with Medical staff.** Responsible Officer: Associate Medical Directors Executive Lead: Medical Director Due Date: 31/03/2025	**Complete**
10	**Raise importance of Hand Hygiene at Clinical Director meeting including review of audit results.** Responsible Officer: Associate Medical Directors Executive Lead: Medical Director Due Date: 31/03/2025	**Complete**
11	**Infection Control Manager to meet with individual Clinical Directors with areas of poor compliance.** Responsible Officer: Associate Medical Directors Executive Lead: Medical Director Due Date: 31/03/2025	**Complete**
12	**Include learning, themes and trends from outbreaks, incidents, spot checks and audits in reports to the Clinical Governance Committee and Board.** Responsible Officer: Infection Control Manager Executive Lead: Director of Nursing, Midwifery and AHPs Due Date: 31/03/2025	**Complete**

Figure 14

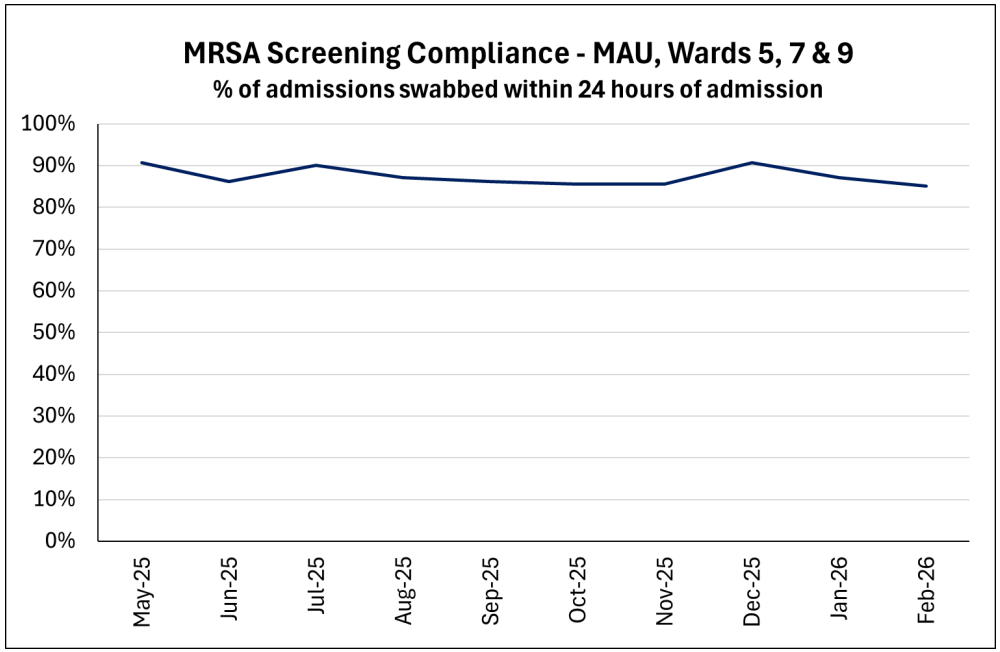


Figure 15

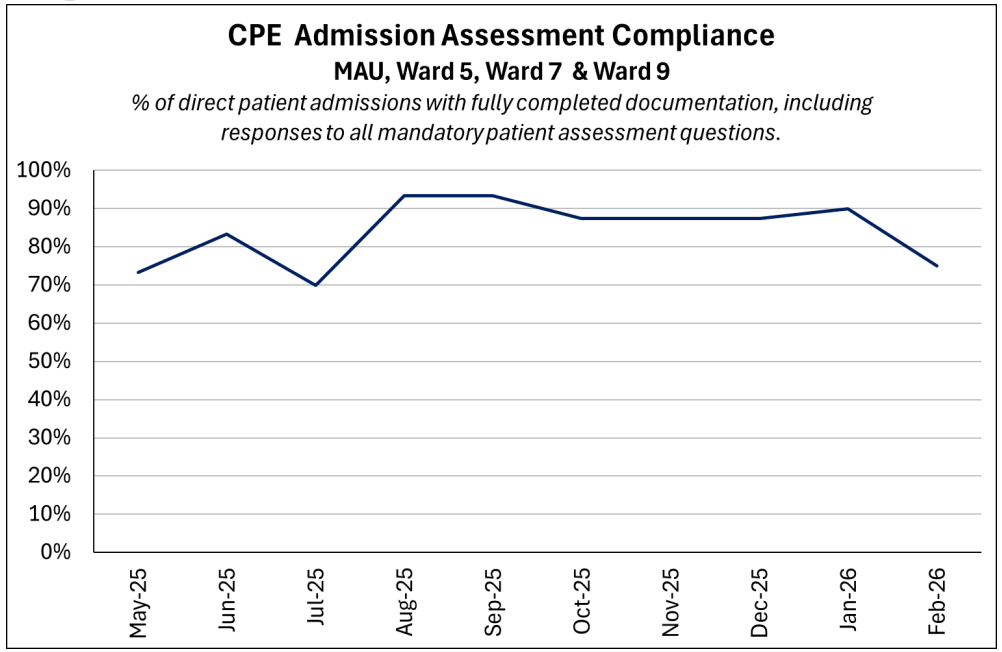


Figure 16

MRSA Uptake	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Borders	90.0%	95.0%	95.0%	95.0%
Scotland	81.4%	81.3%	83.0%	84.8%

CPE Uptake	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Borders	100.0%	95.0%	100.0%	100.0%

Figure 17

Type	Construction/Refurbishment Activity
Type 1	**Inspection and non-invasive activities.** Includes, but is not limited to, removal of ceiling tiles or access hatches for visual inspection, painting which does not include sanding, wall covering, electrical trim work, minor plumbing and activities which do not generate dust or require cutting of walls or access to ceilings other than for visual inspection.
Type 2	**Small scale, short duration activities which create minimal dust.** Includes, but is not limited to, installation of telephone and computer cabling, access to chase spaces, cutting of walls or ceiling where dust migration can be controlled.
Type 3	**Any work which generates a moderate to high level of dust, aerosols and other contaminants or requires demolition or removal of any fixed building components or assemblies.** Includes, but is not limited to, sanding of walls for painting or wall covering, removal of floor coverings, ceiling tiles and casework, new wall construction, minor duct work or electrical work above ceilings, major cabling activities, and any activity which cannot be completed within a single work shift.
Type 4	**Major demolition and construction projects.** Includes, but it not limited to, activities which require consecutive work shifts, requires heavy demolition or removal of a complete cabling system, and new construction.

Figure 18

Risk to patients of infection from construction work in healthcare premises, by clinical areas	
Risk rating	**Area**
Group 1 Lowest risk	1. Office areas; 2. Unoccupied wards; 3. Public areas/Reception; 4. Custodial facilities; 5. Mental Health facilities.
Group 2 Medium risk	1. All other patient care areas (unless included in Group 3 or Group 4); 2. Outpatient clinics (unless in Group 3 or Group 4); 3. Admission or discharge units; 4. Community/GP facilities; 5. Social Care or Elderly facilities.
Group 3 High risk	1. A & E (Accident and Emergency); 2. Medical wards; 3. Surgical wards (including Day Surgery) and Surgical outpatients; 4. Obstetric wards and neonatal nurseries; 5. Paediatrics; 6. Acute and long-stay care of the elderly; 7. Patient investigation areas, including; • Cardiac catheterisation; • Invasive radiology; • Nuclear medicine; • Endoscopy. Also (indirect risk) 8. Pharmacy preparation areas; 9. Ultra clean room standard laboratories (risk of pseudo-outbreaks and unnecessary treatment); 10. Pharmacy Aseptic suites.
Group 4 Highest Risk	1. Any area caring for immuno-compromised patients*, including: • Transplant units and outpatient clinics for patients who have received bone marrow or solid organ transplants; • Oncology Units and outpatient clinics for patients with cancer;

Figure 19

Patient Risk Group	Construction Project Type			
	TYPE 1	TYPE 2	TYPE 3	TYPE 4
Lowest Risk	Class I	Class II	Class II	Class III/IV

Figure 20

NHS Borders Clusters / Closures (01/12/2025 - 26/02/2026)								
Outbreak start date	Outbreak end date	Outbreak location(s)	Ward Closure Status	Organism	Positive patient cases	Patient deaths	Suspected staff cases	Blocked empty bed days
01/12/2025	03/12/2025	BGH, Ward 4	1 Bay	Flu	1	0	0	0
02/12/2025	08/12/2025	Hawick Community Hospital	1 Bay	Flu	1	0	1	0
08/12/2025	08/12/2025	BGH, Ward 9	1 Bay	Flu	1	0	0	1
12/12/2025	23/12/2025	Kelso Community Hospital	2 Bays	Flu	4	0	6	0
11/01/2026	12/01/2026	BGH, Ward 5	1 Bay	Flu	1	0	0	0
15/01/2026	16/01/2026	Hawick Community Hospital	1 Bay	RSV	2	0	0	0
26/01/2026	27/01/2026	BGH, DME	1 Bay	Flu	1	0	0	0
28/01/2026	30/01/2026	BGH, Ward 4	1 Bay	RSV	3	0	0	0
09/02/2026	11/02/2026	Hawick Community Hospital	1 Bay	RSV	1	0	0	0
09/02/2026	17/02/2026	BGH, Ward 4	2 Bays	RSV & Covid-19	7	0	1	2
10/02/2026	12/02/2026	Hay Lodge Community Hospital	1 Bay	RSV	2	0	0	3
10/02/2026	17/02/2026	Kelso Community Hospital	2 Bays	RSV	2	0	0	0
11/02/2026	11/02/2026	BGH, Ward 5	1 Bay	Covid-19	1	0	0	0
12/02/2026	16/02/2026	BGH, BSU	1 Bay	Covid-19	2	0	0	0
23/02/2026	24/02/2026	BGH, Ward 4	1 Bay	Norovirus	2	0	0	0
23/02/2026	24/02/2026	BGH, DME	1 Bay	RSV	2	0	0	0
					33	**0**	**8**	**6**

Organisms and Infections

In March 2025, the Scottish Government wrote to all Boards with new Healthcare Associated Infection (HAI) standards. The expectation is that there should be no increase in the incidence (number of cases) of *Clostridioides difficile* infection (CDI), *Escherichia coli* bacteraemia (ECB), and *Staphylococcus aureus* bacteraemia (SAB) by March 2026 from the 2023/24 baseline

1.1 *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/

1.2 *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

1.3 *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

1.4 Carbapenemase-producing enterobacteriaceae (CPE)

Enterobacteriaceae are a family of bacteria which are part of the normal range of bacteria found in the gut of all humans and animals. However, these organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal infections and bloodstream infections. They include species such as E. coli, Klebsiella sp., Proteus sp. and Enterobacter sp.

Carbapenems are a valuable family of very broad-spectrum antibiotics which are normally reserved for serious infections caused by drug-resistant bacteria (including Enterobacteriaceae). They include meropenem, ertapenem, imipenem and doripenem.

Carbapenemase-producing Enterobacteriaceae (CPE) are a type of Enterobacteriaceae that are resistant to carbapenem antibiotics. These bacteria carry a gene for a carbapenemase enzyme that breaks down carbapenem antibiotics. There are different types of carbapenemases. Infections caused by CPE are associated with high rates of morbidity and mortality and can have severe clinical consequences.

Treatment of these infections is increasingly difficult as these organisms are often resistant to many and sometimes all available antibiotics.

1.5 *Pseudomonas aeruginosa*

Pseudomonas aeruginosa can cause severe infections in people who are immunocompromised or whose defences have been breached, such as oncology patients, neonates, severe burn patients, those with invasive medical devices, and people with cystic fibrosis.

Pseudomonas aeruginosa is commonly found in wet or moist environments and can thrive in water systems. There have been serious outbreaks in adult and neonatal intensive care units, where the cause was thought to have been contamination of the tap water supply.

Appendix C

Graphs and Data

This report routinely includes Statistical Process Control (SPC) charts to analyse data. All systems including healthcare operate with a level of variation. The graphs generally display an Upper Control Limits (UCL) and / or Lower Control Limits (LCL). When the plotted line is within these limits, it is an indication that a system is stable. The graphs help us by highlighting where the amount of variation is exceptional and outside the normal predicted limits which is indicative that something in the system has changed.

2.1 Funnel plots

A funnel plot chart is designed to distinguish natural variation from statistically significant outliers. The funnel narrows on the right of the graph as the larger health Boards will have less fluctuation in their rates due to greater Total Occupied Bed Days (TOBDs). Any plot that is within the blue funnel is not a statistical outlier.

2.2 C Charts

A control chart that monitors the total number of nonconformities (defects) per unit or subgroup. For example, used to analyse the number of infections per month within NHS Borders.

2.3 G Charts

A control chart used to monitor the frequency of rare events over time. For example, the number of days between infections when there are low numbers of cases each month.

Traditional charts which show the number of cases per month can make it more difficult to spot either improvement or deterioration. These charts highlight any statistically significant events which are not part of the natural variation within our health system.

It is important to remember that as these graphs plot the number of days between infections, we are trying to achieve performance above the green average line.

2.4 U Charts

A control chart used to monitor the average number of nonconformities per unit, or defects per unit, when sample sizes can vary. For example, used to analyse infection rates across all Boards in Scotland.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Health & Care (Staffing) (Scotland) Act 2019 - Annual Report**
Responsible Executive/Non-Executive:	**Sarah Horan, Executive Director of Nursing**
Report Author:	**Lynne Boyle, Senior Nurse, Workforce Planning**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Health & Care (Staffing) (Scotland) Act 2019 requires quarterly Board reporting and Annual SG reporting on the NHSB level of compliance with the legislation and the progress being made towards full compliance. The Board requires to be aware of this report and to make any comment as seen to be necessary.

2.2 Background

As of 1 April 2024, the legislation requires quarterly reporting to the Board on how services are progressing towards compliance – this final report in April 2025 is for Scottish Government and will also require to be published. As part of the governance around this process, the Board is asked to review the contents and be aware of this report.

2.3 Assessment

The compliance of the Board against the Duties of the Act is summarised in the report with a compliance status applied to each Duty. As a Board we do not have any areas where there is no evidence of compliance, but our assurance level lies mainly within yellow indicating a reasonable level of assurance in our ability to comply with the legislation. The caveat to this is that some areas/services/teams are further along the journey to compliance than others and the compliance status is indicating the overall Board compliance with the duties of the legislation. There remain challenges in engaging some services although progress has been made in all areas. There is also a lack of documented evidence for many teams in terms of their protocols and processes, which are often established but handed on verbally. Standard Operating Procedures are required and in various stages of development by teams as appropriate. All clinical areas that have specific Staffing Level Tools have a schedule of completion – mandated at 2 weeks minimum each financial year and the Common Staffing Method is applied where tools are run. These SLT outputs should contribute to service reviews in relation to staffing requirements. Assessment of staffing in real time is being addressed through the use of Real Time Staffing Resources or by SafeCare but there remains inconsistency in the use and accuracy of data around both RTSR and SafeCare and roll out of Optima/SafeCare will take some considerable time to complete.

2.3.1 Quality/Patient Care

The aim of the Act is to provide a statutory basis for the provision of appropriate staffing in health and care services, enabling safe and high-quality care and improved outcomes for service users and people experiencing care. This requires the right people, in the right place, with the right skills, at the right time. This will support a rigorous, evidence-based approach to decision-making relating to staffing requirements and consideration of service delivery models and service redesign, acknowledging that local and national recruitment issues and fiscal challenges will impact on the ability to comply with the legislation.

2.3.2 Workforce

Ensuring that sufficient numbers of suitably qualified staff are available will promote safety and quality of patient care but will also enhance staff wellbeing. The aim of the legislation is to provide a transparent decision-making process across the NHS in Scotland where staff have the psychological safety to raise concerns about staffing and for these to be fully addressed in a fully informed manner and with feedback to staff on how decisions are reached. A reduction in reliance on supplementary staffing will result with associated cost savings and recruitment and retention will increase.

2.3.3 Financial

Having appropriate staffing in terms of numbers, skills and training will enhance patient care which can lead to reductions in length of stay and less likelihood of care related harm to patients. Complaints and litigation will reduce and the reliance on costly agency staff can be eliminated creating savings for the Board. Sickness absence levels likely to reduce with enhanced staff wellbeing, leading to further cost reduction.

2.3.4 Risk Assessment/Management

The overall aims of the legislation are to improve well being of staff as well as enhancing the safety, quality and effectiveness of care provided for patients.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed locally because this relates to national legislation.

2.3.6 Climate Change

NA

2.3.7 Other impacts

NA

2.3.8 Communication, involvement, engagement, and consultation

The Board has carried out its duties to involve and engage relevant stakeholders where appropriate through presentations to Clinical Boards, APF, LPF meetings, MOG meetings, and SCN/CNM meetings. Communications have also gone out globally within the Board around HCSA 2019.

2.3.9 Route to the Meeting

This has been previously considered by the Staff Governance Committee in the previous quarter as part of its development.

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 No,1 – Summary Report on NHSB Compliance with duties of HCSSA 2019

NHS BORDERS

NHS BOARD

EXECUTIVE SUMMARY PAPER

Meeting: NHS Board

Meeting Date: 2 April 2026

Title: Q4 Board Report/Annual SG Report – Health and Care (Staffing) (Scotland) Act 2019

Responsible Executive: Sarah Horan – Director of NMAHP

Report Author: Lynne Boyle – Senior Nurse Workforce Planning

1. PURPOSE

This Executive Summary Paper provides the NHS Board with a high-level overview of NHS Borders' progress during Quarter 3 (October–December 2025) in meeting the statutory requirements of the Health and Care (Staffing) (Scotland) Act 2019.

2. OVERALL POSITION

NHS Borders demonstrates reasonable assurance against the duties of the Act, with progress visible across multiple domains.

3. KEY ACHIEVEMENTS IN QUARTER 3

Strengthened use of staffing tools; rollout of Optima/SafeCare; development of new and enhanced services.

4. KEY RISKS AND CHALLENGES

Workforce pressures, Potential impact of reduced working week and other non-financial aspects of the agenda for change pay award, training compliance issues, and system interoperability remain significant risks.

5. SUMMARY AGAINST DUTIES

NHS Borders continue to make good progress against the duties, providing requested evidence to HIS as requested, under their duty to enquire within the legislation through.

6. FORWARD LOOK

Eroster and SafeCare rollout, consideration for international recruitment to stabilize workforce where demonstrated as required, work towards consistency of application of processes across all services.

7. RECOMMENDATION

Board Members are invited to note progress and advise on any further assurance required.

HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 – NHS BORDERS ANNUAL REPORT 2026

Report approval

1. The box below should be completed by the person signing off the report. An electronic signature is acceptable.
2. The Act requires the annual reports to be published by relevant organisations. Please enter a hyperlink to the webpage where the report can be found in the boxes below.

Name of organisation:	**NHS BORDERS**
Report authorised by:	**Sarah Horan**
	NMAHP Director
	20 March 2026
Location where report is published:	nhsborders.scot.nhs.uk/corporate-information/about-the-board/

GUIDANCE ON USING THIS TEMPLATE

Purpose

This guidance has been developed to support relevant organisations in the completion of the below template which will form their annual report detailing compliance with the requirements of the Health and Care (Staffing) (Scotland) Act 2019 (the Act). Completed reports must be returned to hcsa@gov.scot by 30 April 2026.

Additional resources can be accessed here: Health and Care (Staffing) (Scotland) Act 2019: statutory guidance - gov.scot

If you require further assistance or have any queries, please contact hcsa@gov.scot.

Summary Section

3. The summary asks for an overview of how the relevant organisation has carried out all of the duties and requirements of the Act. This should include all NHS functions provided by all professional disciplines covered under the Act. You will be asked to provide an assurance level in respect of your overall compliance with the Act. Definitions for these assurance levels can be found at point seven.

4. Following receipt, the Scottish Ministers must collate reports from relevant organisations and lay a combined report before Parliament, along with an accompanying statement setting out how the information will be taken into account in policies for staffing of the health service. To enable this process, the information provided by relevant organisations should be comprehensive and pertinent to the staffing of the health service. To enable this, please complete the questions contained in the reporting template in sufficient detail, setting out the key achievements, outcomes, learning, and risks and how this information has been used to inform workforce planning at the local level.

Individual duties / requirements

5. Following the summary section, the template seeks detail on individual duties/requirements of the Act in turn, asking relevant organisations to provide an assessment of compliance, and to provide details. Again, this should include all NHS functions, provided by all professional disciplines covered under the Act. Relevant organisations should provide detail to explain the assurance level in respect of the Duty, detailing evidence of compliance where appropriate, or gaps and areas of ongoing focus.

   Evidence could, for example, include details of the organisational structures, systems and/or processes being used.

6. The duty description contains the legislative wording of the Act, outlining the duty requirements.

7. As outlined at paragraph 3, the template requests an overall level of assurance with regard to the relevant organisation's compliance with the Act/Duties, using the assurance categories as detailed below:

Level of assurance	System adequacy	Controls
Substantial assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable assurance	There is a generally sound system of governance, risk management, and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non- compliance.
Limited assurance	Significant gaps, weaknesses, or non- compliance were identified. Improvement is required to the system of governance, risk management, and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

8. The relevant organisation is asked to provide details of areas of success, achievement and learning associated with the particular duty or requirement, along with indicating how this could be used in the future. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to complete this with an appropriate level of detail.

9. The relevant organisation is then asked to provide details of any areas of risk where they have been unable to achieve or maintain compliance with the particular duty or requirement, or where they have faced any challenges or risks in carrying out their duties or requirements. In this section, relevant organisations are also asked what actions have been or are being taken to address this. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to provide an appropriate level of detail.

ANNUAL REPORTING TEMPLATE

Summary

Please answer the following questions, to provide an overall assessment of how the organisation has carried out its duties under sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL of the National Health Service (Scotland) Act 1978 (inserted by section 4 of the Act), and in line with Sections 1 and 2 of the Act : Guiding principles for health and care staffing and Guiding principles etc. in health and care staffing and planning.

Please advise how the information provided in this report has been used or will be used to inform workforce plans.
Summary on how the information within this report has/or will inform future workforce plans/planning. Examples include - but not limited to: • Impacts and outcomes of real -time staffing assessment on workforce/workload planning • How the outputs of the Staffing Level Tools and the application of the CSM have informed you workforce planning activity. • Impact of the Health and Care Staffing Act has led to safe and efficient staffing.
The information in this report is collated from Quarterly Board Reports and feedback from clinical professional leads. Overall strategic direction of the HCSSA legislation for NHS Borders is guided by the Health and Care Staffing Programme Board which meets every 6 weeks, with representatives from all clinical professions. Workforce planning locally is influenced by the HCSSA legislation. For those professions with a specialty specific staffing level tool, these are run according to an annual schedule and the results of these tools feed into the use of the Common Staffing Method which looks at a number of factors influencing staffing, such as current funded and actual establishments, the local context of care delivery, clinical quality indicators, safety data and other KPIs. Appropriate governance is sought through line management routes and decisions are made as to whether any increase in establishment is required and to support business case development. Use of the Common Staffing Method also ensures that Clinical Leads can examine in-house practices to ensure that the best possible use is made of available staffing resources. Outputs from Staffing Level Tools and Common Staffing Method have also been used within Service Reviews commissioned across the Board to identify staffing requirements and future funding levels. Workforce Planning locally feeds into annual workforce plans and uses a variety of methodologies and strategies to facilitate best use of resources, recruitment, retention, and employability initiatives. Use of Real Time Staffing Resources or Optima eRoster/SafeCare (where rolled out) enables visible and transparent assessment of staffing including the professional judgement of staff as to the safety of staffing numbers and skill mix. It also enables the reporting on recurrent or severe risks and trends associated

with staffing and the outputs are used at each Daily Safety Brief/Staffing Huddle to support decision making and ensure the safest possible staffing of all areas each day and subsequently increased production.

the identification of recommended Whole Time Equivalents from Specialty Specific Staffing Level Tools and Professional Judgement Tools, other work internally, including staffing audits enable identification of staffing requirements/deficits in future due to attrition, recruitment challenges etc so that initiatives can be established to ensure that recruitment is maintained in line with need.

There is now greater awareness across all professions of the need to assess staffing in real time and to have processes for escalating risks, mitigating, or managing risks. The revised Professional Judgement Tool on SSTS can also be utilised more widely by other professions to assess staffing requirements, alongside guidance from their professional bodies.

Please provide information on how your compliance to the Health and Care Staffing Act has led to improved outcomes for service users and workforce

As set out in the legislation, compliance with the Act should support the outcomes from the Health and Care Standards. Therefore, you should demonstrate/consider how implementation of the Act contributes to achieving these Standards

This should include - but not be limited to - information in relation to patient safety and quality of care measures and outcomes, patient feedback, staff wellbeing measures, and adverse event reporting; what this information has shown and any trends; and any actions taken as a result.

The Health and Care Standards ensure high-quality, person-centred care through the principles of dignity/respect, compassion, inclusion, responsiveness, and wellbeing. Each of these elements are threaded through the Health and Care Staffing Act and the duties that each Board must comply with. Implementation of the Health & Care Standards can only be achieved if staffing levels are safe and adequate to provide the level of care required of the patient/client population served, therefore increasing awareness of the Act and implementation of processes to support this naturally leads to enhanced compliance with the Standards.

Locally each professional lead is required to provide a summary of how the service they lead, complies with each duty of the Act. This is done via a template that is circulated, with guidance, as to the considerations that should be included.

All services must provide information on the quality and safety of the service and care that they provide. This includes looking at Safety Data including InPhase adverse incident reports, SAERs as well as Quality data from Clinical Quality Indicators and other KPIs relevant to their service e.g. waiting lists, delays. They need to examine trends and also consider whether these trends are being positively or negatively influenced by staffing levels and skill mix. Review of complaints, commendations and feedback from patients/carers including that published on Care Opinion helps to identify both what is working well in services and where patients/carers experience shortcomings. Each service must examine their own data to see trends, and these are looked at collectively at Clinical Management Team meetings with action plans to address any concerns.

Whistleblowing standards are also known to staff with a list of Confidential Contacts available locally to discuss any concerns that may be in the public interest.

Staff wellbeing measures are made available via a Staff Wellbeing Group, Staff Wellbeing initiatives and Occupational Health Service. Staff voices are listened to at daily safety briefs and staffing huddles and also through appraisals, clinical supervision and 1:1 support from managers. iMatter is used annually and action plans generated at team level once results are available to be reviewed and analysed.

Bi-annual Board Review Meetings with representatives from HIS following a 'key lines of enquiry' approach enables discussion at local level regarding compliance with the legislation and the work that is being undertaken by services to move towards full compliance. HIS inspections or further requests for information under their power to exercise the right to request additional evidence helps NHS Borders to identify priorities to work on and enables sharing of good practice and learning.

Where surge capacity beds have had to be opened/remain open, there has been non-recurring funding made available for staffing in accordance with Professional Judgement where no recent staffing tool data is available. Where surge capacity beds have fluctuated frequently, supplementary staffing has been used and captured as a cost pressure.

NHS Borders has made a significant improvement to elective waiting lists as well as access to cancer treatment pathways and staffing levels have been modelled to enable the opening of a frailty unit and to expand Home First and Hospital at Home services to ensure increased patient safety and greater patient satisfaction as well as increasing flow through Acute services.

The tension between financial constraint and safety ambitions needs to be acknowledged. Whilst it is unrealistic to expect unchecked growth, staff look for realistic establishments, protected leadership time, visible clinical leadership, and honesty regarding staffing decisions made with the opportunity to voice concerns around safety which are fully listened to and acted up in the fairest and safest manner.

Health and Care Staffing Act Health Board Duty Compliance Assurance Levels

Please complete the table below with your Health Boards compliance assurance level for each duty.

DUTY	COMPLIANCE ASSURANCE LEVEL
Duty 12IA: Duty To Ensure Appropriate Staffing	Reasonable Assurance
Duty 12IC: Duty To Have Real-Time Staffing Assessment In Place.	Reasonable Assurance
Duty 12ID: Duty To Have Risk Escalation Process In Place.	Reasonable Assurance
Duty 12IE: Duty To Have Arrangements To Address Severe And Recurrent Risks.	Reasonable Assurance
Duty 12IF: Duty To Seek Clinical Advice On Staffing.	Reasonable Assurance
Duty 12II: Duty To Ensure Appropriate Staffing: Training Of Staff	Reasonable Assurance
Duty 12IH: Duty To Ensure Adequate Time Given To Clinical Leaders.	Limited Assurance
Duty 12IJ: Duty To Follow The Common Staffing Method (CSM)	Reasonable Assurance
Duty 12IL: Training And Consultation Of Staff	Reasonable Assurance
Planning And Securing Services	Reasonable Assurance
PLEASE INDICATE THE OVERALL LEVEL OF ASSURANCE OF THE ORGANISATION'S COMPLIANCE	
Reasonable Assurance	

Duty 12IA: Duty to ensure appropriate staffing

Duty Description	**2 Guiding principles etc. in health care staffing and planning** (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. **Duty 12IA: Duty to ensure appropriate staffing.** (**1) It is the duty of every Health Board and the Agency to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate** for— (a) the health, wellbeing, and safety of patients, (b) the provision of safe and high-quality health care, and (c) in so far as it affects either of those matters, the wellbeing of staff. (**2) In determining what, in a particular kind of health care provision, constitutes appropriate numbers for the purposes of subsection (1), regard is to be had to—** (a) the nature of the particular kind of health care provision, (b) the local context in which it is being provided, (c) the number of patients being provided it, (d) the needs of patients being provided it, and (e) appropriate clinical advice.

Please provide information on the steps taken to comply with Duty 12IA.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- Professional Leads are asked to complete a standardised template to report current compliance with the duties, within their areas of professional responsibility. These reports are requested quarterly with consideration of responses to inform quarterly Board Reports.
- The template asks for information on each specific Duty of the HCSSA 2019 including details of actions being taken by individual services to reach compliance with the legislation.
- All clinical professionals that have a national specialty specific Staffing Level Tool (HIS) undertake completion of tools in accordance with the legislative recommendation of 2 weeks in each financial year. This includes concurrent use of the Professional Judgement Tool and Quality Tool as appropriate, and forms part of the mandated Common Staffing Method.

- Where applicable the Common Staffing Method allows professional leads and their teams to look at the local context in which care/service is delivered including the numbers and types of patients receiving care, the quality of care as demonstrated by audits of clinical quality indicators, the safety of care as demonstrated by risks identified through risk assessments, Risk Register and risks recorded as part of InPhase reporting of adverse clinical incidents. Workforce data is included such as current funded establishments, rWTE outputs from Tools, rWTE outputs from Professional Judgement Tools and concerns identified within Quality Tool reports where applicable. Other information considered includes vacancies, barriers to recruitment, turnover of staff, absence levels, training and development of staff and support for staff development and wellbeing. Waiting times as well as feedback from patients/service users is also considered.
- Many clinical professions/services do not have HIS Staffing Level Tools and so variously use national guidelines produced by their Professional Bodies e.g. RCP, HPC, GDC or NICE etc and local service reviews to underpin Workforce Planning requirements. There are also existing services that do not have national recommendations for minimum staffing levels, in which case DCAQ modelling and use of Professional Judgement provide an evidence base for staffing requirements. Some outpatient services and specialist nursing services use core activity to identify staffing numbers, skills and expertise required, whilst other services use Capacity and Demand calculators specific to their clinical remit. If there is no tool that is felt to satisfactorily reflect workload then the Professional Judgement Tool is used.
- Outputs from Tools are variously used in Workforce Planning, Succession Planning and as part of Service Reviews within NHSB. The further reduction in the working week from April 2026 is accounted for in Tool outputs and helps with identifying resource requirements.
- In a small Board such as NHSB, some services are run by single practitioners which makes them vulnerable during times of unplanned absence. Use of Agency staff/Locums invariably is required and does drive up costs in order to sustain critical patient services.
- International recruitment has previously been successful across Nursing, Medical, some AHP posts and radiography. Notably international recruitment places additional costs on the Board when no central funding is allocated from SG. It is recognised locally that further international recruitment will be required over the next few years to sustain nursing complements.
- Other contingencies include regional working arrangements for out of hours, but vulnerability of such services needs to be acknowledged. Other innovations include outsourcing of some work to ensure sustainability of service, patient safety and staff wellbeing e.g. enabling a shift system to be employed rather than on call working.
- Work is ongoing across professions in combination with HR to promote succession planning – some areas have ageing workforces and specialist team staffing requirements need to be addressed via innovative recruitment and training initiatives.
- Many services have undergone or are in the process of undertaking Service Reviews with assessment of staffing capacity to inform any redesign of service as required. Business cases are informed by these reviews in order to secure necessary funding.
- Proactive management of staff absence and a growing staff wellbeing service are used to manage levels of absence although there are frequent episodes where the nationally recognised level of sickness absence (4%) is breached necessitating use of supplementary staffing at additional cost to the Board.
- Recent new and expanded services – Hospital at Home, Home First and Immediate Discharge Team are developing SOPs to support compliance with Duties of legislation and are moving on to SafeCare within the first month of new financial year to ensure that staffing assessments, risks, mitigations, escalations and decisions/clinical advice can be recorded by all staff.

- Lack of oversight of NHS General Dental Practitioners (GDPs), Optometrists and GPs who operate as independent contractors, creates a structural limitation in applying and assuring compliance with the Health and Care (Staffing) (Scotland) Act 2019, which places duties on Health Boards to ensure appropriate staffing, risk escalation, real-time assessment, and staff training. As practitioners in these contracted services are not employees of the Health Board, the Board cannot directly require or enforce compliance with Duties such as 12IA (appropriate staffing), 12IC (real-time staffing assessment), 12ID (risk escalation), 12IE (severe/recurrent risk management) or 12IL (training/knowledge of the Act). Planning of Services under the legislation does enable Boards to identify the level of service that will be provided via Contracting and Procurement processes.
- Theatres/ITU/CCOT/Preassessment/Chronic Pain Service have Implemented revised workforce planning including targeted recruitment and improved retention incentives. Introducing digital workload tool will streamline safe-staffing data and improve accuracy of reporting. There is also expansion of internal upskilling programme to reduce reliance on external training availability.
- Cognisance is given to fact that numbers of staff alone does not confirm compliance with this duty. While establishments may appear filled, the distribution of experience within teams has shifted significantly. Large cohorts of newly qualified nurses, accelerated progression into Band 6/7 roles, and the post-pandemic exit of senior leaders have reduced the “experienced core” on shifts. The impact is not just technical skill gaps but diminished clinical judgement under pressure.
- Predicted Absence Allowance, where included in individual budgets, is set at 21% in NHSB. This is against a recommendation by SG of 22.5% which is also included in Staffing Level Tool outputs. Consideration is being given to the need to consistently increase PAA to 22.5% as part of ongoing Workforce Planning across services.
- The demand for healthcare services often exceeds the available workforce, leading to staffing shortages and increased pressure on existing staff. Additionally, balancing the allocation of nurses across various departments and shifts can be complex, requiring careful planning and coordination.
- NHS Borders runs a standardised recruitment process through the East Region Recruitment Service (ERRS), hosted by NHS Lothian, using the national Jobtrain System and Standard Operating Procedures (SOPs). The Nursing, Midwifery and Allied Health Professionals (AHP) Recruitment Oversight Group, chaired by the Associate Director of Corporate Nursing, meets monthly and reports to the NHS Health and Safety Staffing Board and the NHS Borders Staff Governance Committee to steer recruitment, development, and retention. Policies and tools in use include the Workforce Flexible Work Pattern Policy, staffing tools, e-rostering and Workforce Statistical Process Control (SPC) charts that track vacancies, Whole Time Equivalent (WTE) and sickness absence, with concerns escalated through Clinical Governance and Risk Management committees.
- NHS Borders has clear and detailed policies for workforce flexibility, education, recruitment, and attendance management. The Workforce Flexible Work Pattern Policy offers a framework for flexible work options. The Recruitment and Retention Premia Policy tackles staffing challenges through proactive planning and non-financial incentives. The Attendance Management Policy supports employees with health-related attendance issues, ensuring clear procedures and responsibilities. NHS Borders supports staff wellbeing with services like psychology and occupational therapy, alongside activities during a dedicated Wellbeing Week to promote a healthy work environment. Staff feedback mechanisms such as the iMatter Questionnaire provide an opportunity for open communication and continuous improvement by gathering insights on staff engagement, leadership, communication, and wellbeing.

- Collaboration between Organisational Development and Occupational Health to prevent burnout through coaching. Staff networks, including minority ethnic, disability, and 'LGBT+' groups, advocate for change and improvement by facilitating communication between workers and Management.

Please provide Information on your methods of monitoring compliance with Duty 12IA

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- A daily Safety Brief is held within the Acute Services which all professions are enabled to attend. Similarly, within MHLD and Primary and Community Services there are daily safety huddles attended by staff and managers where information (professional judgement) on staffing levels is collated, risks identified, mitigations created and escalations initiated to ensure best level of patient safety and action planning and to ensure that staff voices are heard.
- Use of Real Time Staffing Resources and also SafeCare (which is currently rolling out across the Board) enable identification of staffing and safety risks in real time and facilitate mitigation through overview of all services and areas. This will promote a unified and streamlined approach to compliance, monitoring, and reporting.
- Currently there are 53% of medical staff and 58% of Nursing & Midwifery Staff using Optima eRoster with continued roll out to use of SafeCare.
- Whilst some services have national guidelines on staffing requirements, locally some workload demand is outstripping capacity therefore staffing is being reviewed, with a further consideration being given to the amount of travel time that has to be factored in when covering a large rural geographical area e.g. Community Nurses, DNs and HVs.
- DCAQ modelling is being used to establish safe baseline/funded establishments within AHP services. Similarly benchmarking in Public Protection with other Board areas includes development of Workload Tools specific to that service. Psychology and Public Dentistry are also working with Public Health Scotland to build workload tools that are bespoke to their services.
- Performance e.g. waiting lists, complaints, quality reports are used to identify if staffing requirements are being met.
- Regional Recruitment is in place and performance is agreed and reviewed jointly by NHSB and NHS Lothian.
- Where absence remains higher than agreed national levels, improvements have been made to reporting on ‘hotspots’ with targeted support from HR colleagues and feedback monthly to CMT meetings for review, escalation, and further mitigation.
- Staff opinions and concerns are also obtained through InPhase reports, Supervision, Appraisals, 1:1s and iMatter so that patient safety and staff wellbeing can be addressed.
- A recently approved Clinical Strategy and other enabling strategies in development aim to address ongoing/emerging trends in staffing requirements and the need to shift the balance of care and resources.
- Roll out of Power Bi reports to provide a single source of truth to Clinical/Professional leads regarding Workforce data across NHS Borders.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, application of eRostering has allowed senior personnel to be able to see staffing in real-time across all areas, allowing staff to be reallocated as required to reduce level of risk.	This should describe how the success, achievement or learning could be used in the future. For example, continue the roll out of eRostering across the organisation, using learning from areas that have already implemented.
Use of Real Time Staffing Resources on TURAS and roll out of eRostering/SafeCare	• Implementation of eRostering has allowed senior personnel to be able to see staffing in real-time across all areas, allowing staff to be reallocated as required to reduce level of risk	• Roll out of eRoster and SafeCare will continue across the entire organisation through 2026/27 prior to retirement of SSTS. • Learning is being obtained from areas that have already implemented Optima and from other Boards via the Knowledge network and the product provider RL Datix.
Medical staffing	• Enhanced by the successful recruitment of Clinical Development Fellows and increased numbers of Doctors in Training (DiTs) have been agreed by the Deanery.	• Continue to provide appropriate training opportunities and comply with medical training requirements to ensure that NHSB continues to attract CDFs and has optimum allocation of DiTs by Deanery.
Director of Corporate Nursing role	• Provides support to clinical areas in improving and bringing consistency to workforce management, focusing on implementing new workforce models to improve forecasting and staffing strategies. Leads on capacity and demand planning for inpatient, emergency and other units using Finance System data and SCN intelligence in tandem with Senior Leadership Team reviews in Mental Health & Learning Disabilities.	• Focus on demand forecasting and succession planning across all areas. • Address feedback from exit interviews to ensure improved service delivery and staff retention.
Nursing Establishment changes due to Reduced Working Week (RWW)	• Locally, reviews of staffing establishments required following implementation of the full reduction to the working week have been undertaken prospectively.	• Funding from SG to be allocated for areas that require support with full reduction of working week.

	• Potential shortfall in establishments creating additional challenges to recruitment both practically and financially. • Additional workload due to changes to roster planning and shift patterns,	• Funding agreed locally to recruit further newly qualified practitioners and international recruits to fill projected/emerging staffing requirements. • Close working with HR and eRostering Teams to ensure smooth transition and share learning.
Audiology	• Recently completed UKAS (IQUIPS) bench marking external visit, a requirement from the Scottish Government, current benchmarking taking place within all Audiology departments throughout Scotland.	• Source income locally or centrally to fund any additional staffing requirements identified by Benchmarking process.
Public Dental Services	• Service has embedded systematic, repeatable approaches to workforce planning, decision-making, and monitoring, underpinned by governance and robust data.	• Continue to use strong organisational data sources to support decisions and drive proactive planning and monitoring of patient activity, access and waiting times.
Newly Qualified Practitioners (NQPs)	• A Standard Operating Procedure for the recruitment of NQPs ensures a smooth recruitment process with clear timelines and responsibilities for each stage of recruitment across Nursing Services.	• Share learning and resources with other professions in order to streamline recruitment process of newly qualified staff.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with recruiting a particular staff speciality or recruitment in a remote / rural location.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in recruiting in a particular speciality or remote / rural location, the relevant organisation may have investigated retire and return schemes or upskilling and career development for existing staff. It may also have looked at how the service could be redesigned.

National and local recruitment difficulties impact on NHSB as a small and relatively rural Board, particularly for come Medical Consultant posts and for specialised A4C posts.	• Medical consultant vacancies have been difficult to recruit to in some specialties e.g. Dermatology and some Psychiatry. Likewise, recruitment to specialist nursing and AHP posts can be challenging in our small rural Board.	• Actions taken to address these difficulties have included the use of International Recruitment, employment of Clinical Development Fellows, Employability initiatives identified through Workforce Planning and some incentivisation for posts where appropriate. Regional working has been implemented in some services and the use of Telemedicine to support clinical work has been initiated. • Service reviews have taken place or are in development across most services to look at service redesign and/or staffing requirements. • Occasional use of long-term locums has been used to support medical staffing.
Acute Services Nursing	• When surge beds are required to open, staffing above establishment is required and not always available even when relying on Bank/Agency.	• Audit of projected nursing requirements to look at actual staffing needs, considering surge bed staffing requirements. • Ongoing work both in hospital and community to reduce the number of surge beds required through introduction of expanded community care services.
Laboratories	• It is often not possible to protect the time for quality management and leadership activities, as senior staff currently cover the OOH service or are the mitigation for band 5/6 staff shortages in the laboratory. • Protected learning time allocated but often used as mitigation to provide a laboratory service when staffing levels are unsafe. • There is a significant risk of service failure should there be a short notice absence for a shift. Due to small pool of trained BMS staff there is insufficient staff numbers to implement a second on-call staff to cover for shift absences.	• Following laboratory staffing issues and resource issues raised by UKAS and MHRA, additional resource was agreed by NHSB and has been recruited to with ongoing review. • SBAR to Executive Team to highlight risks of Reduced Working Week and requirement to backfill hours. • Update to Chemistry, Haematology and Blood Transfusion Capacity plans ongoing. • External Workforce review has been agreed by laboratory programme board. • MLSO and Microbiology capacity plans to be completed.

	• Changes in laboratory information system, analysers and increases in QMS workload with new ISO 15189:2022 standards.	
Audiology	• Inability to qualify as a Band 5 audiologist in Scotland • Lack of suitable applicants for advertised Band 6 posts	• Liaise with CWS to look at innovative recruitment pathways to audiology.
Chaplains	• Very small team that is unable to deliver 24/7 service, especially during any staff absences, without reliance on community faith representatives.	• Consideration of outputs from The Scottish Professional Leads Group (PLG) in Spiritual Care, which is presently devising a new "data collection" method to capture impact on service users. • Ensure diversity of skill set across the Spiritual Care Department to accommodate all faiths within small rural community.
Borders McMillan Centre	• Imminent challenges to recruitment, retention, and morale of Band 6 and 7 post holders through expected outcomes of the Band 5 review. This is highly likely make it impossible to replace band 6 postholders who are Prescribers and or have management responsibility, and very challenging to motivate current B6 postholders to line manage fellow B6's or will result in the B7 SCN having an unrealistic number of staff to directly line manage.	• Highlight specific staffing risk on Risk Register • Work with managers to identify specific role plans. • Identify ways of ensuring sufficient prescribing resource within department. • Share learning with other teams in NHSB who may face similar issues following B5 Nursing Review.
Public Dental Service	• Lack of a national Dental Workforce Staffing Level Tool • National and local recruitment challenges coupled with absence, maternity leave and retirements in a small team creates service vulnerability.	• Link to work nationally with PHS to contribute to bespoke Staffing Level Tool development. • Maintain structured reporting of anticipated staffing gaps (retirements, long-term illness). • Continue engagement with national workforce planning groups.

COMPLIANCE ASSURANCE LEVEL

Reasonable Assurance

Duty 12IC: Duty to have real-time staffing assessment in place.

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the real-time assessment of its compliance with the duty imposed by section 12IA.** **(2) The arrangements under subsection (1) must, in particular, include—** (a) a procedure for the identification, by any member of staff, of any risks caused by staffing levels to— (i) the health, wellbeing, and safety of patients, (ii) the provision of safe and high-quality health care, or (iii) in so far as it affects either of those matters, the wellbeing of staff, (b) a procedure for the notification of any such risk to an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, (c) a procedure for the mitigation of any such risks, so far as possible, by such an individual, and a requirement for that individual to seek and have regard to appropriate clinical advice, as necessary, in carrying out such mitigation, (d) raising awareness among staff about the procedures described in paragraphs (a) (b) and (c), (e) encouraging and enabling staff to use the procedures described in paragraphs (a) and (b), (f) training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (e), and (g) ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12IC.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- All ward areas across Acute and Community Hospitals are using/introducing Real Time Staffing Assessments either on TURAS, or via Optima Health Roster/SafeCare where implementation is complete. Mental Health Inpatient wards and Acute Unscheduled Care wards have fully transitioned to SafeCare with Maternity services transitioning to SafeCare in near future. SOPs are in place to identify risk escalation and mitigation procedures to be followed.

- Other Clinical areas are in the process of using TURAS resources while the transition to SafeCare is rolled out with some using bespoke systems e.g. Via SharePoint to record real time staffing assessments, risks, mitigations, and clinical advice sought at Safety Huddles.
- Staff are encouraged to use Professional Judgement to highlight areas of risk and determine remedial actions at Safety Brief/Huddles. There are recording on staffing escalation decision sheets or via RTSR and SafeCare.
- SOPs for escalation of staffing risks have been developed within Acute and Primary Care services and will continue to be developed for any new services e.g. Hospital at Home, Home First and the Frailty Unit which have recently been initiated/enhanced.
- Medical Teams in some areas continue to use bespoke systems for recording staffing risks and mitigations. Whilst use of Optime eRoster and SafeCare has triggered increasing interest and has been initiated in discrete medical teams, there remains dubiety between SG and the supplier of the product, RL Datix, as to the suitability of SafeCare for Medical Staffing.

Please provide Information on your methods of monitoring compliance with Duty 12IC

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- All clinical areas attend the Daily Staffing Brief in Acute Services or the Daily Staffing Huddles within Primary & Community Services where staffing is discussed in real time. Any services that fail to attend and discuss their staffing are contacted and an update is requested.
- Managers have access to TURAS RTSR and can see which wards are completing these and how often as well as responding to escalations.
- Increasing use of Optima eRoster and SafeCare allows for visualisation of the 'sunburst' to see which areas are using their Census periods correctly and to identify if Professional Judgement is being applied, with managers investigating any slippage to their use.
- The eRostering Team provide additional support and assistance where teams are struggling to use eRoster and/or SafeCare and will provide targeted support to individual team leads and team members.
- Any concerns/near misses or adverse events reported on InPhase regarding staffing levels can be checked against information provided at Safety Huddles to ensure that staffing is being assessed in Real Time.
- Use of TURAS Real Time Staffing Resources and eRoster/Self Care can facilitate the assessment, escalation, mitigation of emerging and actual risks.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, areas that have implemented and are using SafeCare are able to accurately record risks that are identified and the mitigation measures	This should describe how the success, achievement or learning could be used in the future.

	implemented, and clinical advice received. Reports extracted from the system are demonstrating an auditable trail of decision-making.	For example, this success is being used to demonstrate to other areas the benefits of using SafeCare and supporting its implementation.
• Laboratory has developed a real-time staffing tool	• This Excel tool captures daily staffing levels, skill mix, safe to start data, mitigations used and escalations. Monthly, quarterly, and annual reports are generated. • Capacity plans for laboratory developed for Blood Sciences/Blood transfusion which has guided required staffing numbers. Capacity plans have taken in to account all laboratory activities, including those essential for maintaining the quality management system.	• The set safe staffing levels will be reviewed quarterly to ensure any changes in workload or staffing are considered.
• Psychology	• Recognition that existing Real Time Staffing resources may not be the best fit for the services therefore collaborating with colleagues in Public Health Scotland to develop bespoke resource that can provide auditable reports on decision making.	• Learning to be shared with other services to support implementation of real time staffing assessments, escalation, and mitigation of risk.
• Heightened awareness of HCSSA 2019 legislation and Duty 12IC to have Real Time Staffing Assessment in place.	• All areas report having a system of assessing their staffing in real time although these vary and some are less formal than TURAS or OPTIMA platforms.	• Support from Senior Nurse (Workforce Planning) to continue raising awareness and encouraging engagement with and implementation of systems.
• Mental Health Team	• The morning safety huddle for staff has moved from being exclusively inpatient to incorporating the community mental health services. Services review current concerns, sickness, absence, and escalating risks. Staffing is deployed to support areas where risk is identified and recorded on SafeCare.	• Where staff are deployed to another unit it is based on the needs of both services. This will include skills evaluation. (e.g. Relevant clinical practice, PMAV levels, Enhanced clearance etc). Continual review of staff deployment.
• Public Dental Services	• Full implementation of the Public Health Scotland Real-Time Dentistry Staffing Assessment Tool across all clinics.	• Feedback from Professional Lead to Health and Care Staffing Programme Board to share learning and good practice.

	• Daily huddles and dynamic risk assessments embedded and consistently used.	
• ITU and OPD	• Utilisation of Optima eRoster/SafeCare and robust Critical Care Staffing Model in place.	• Ability to improve rota stability and reduce reliance on agency staffing – good practice to be shared with other units.
• Theatres, Critical Care Outreach, Preassessment and Chronic Pain Services	• Consistent multidisciplinary attendance at Daily Safety Huddles with use of SBAR communication. • Use of TURAS Real Time Staffing for assessment and escalation of identified risks.	• Sharing of good practice and learning across all services in department.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with encouraging and enabling certain professional groups to use the systems and processes.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in engaging certain professional groups, what measures have been put in place with regard to increasing this such as using professional networks, staff representatives etc.?
• Some services e.g. Dermatology and Audiology	• May mitigate unsafe staffing levels by cancelling clinics – beginning with those of lowest clinical need, if appropriate staffing cannot be sourced • This ensures safety but impacts on quality of care and waiting lists.	• Legislation has led services to consider benchmarking with other Boards, regional support networks, and increased scrutiny on managing services with limited staffing and no available supplementary staffing.
• Complete roll out of Optima eRoster/SafeCare unlikely to be complete until late 2027 due to pressure on services and inability to release staff to learn systems.	• Multiple systems of Real Time Staffing in use. • Completion of census periods remains erratic in services using the systems. • Staff find systems labour intensive and there is a need for encouragement to engage some staff groups.	• eRostering Team has been made permanent ensuring that training and support is available to staff beyond implementation – it is anticipated that this requirement will be ongoing for considerable time.

	• Roll out of eRoster/SafeCare will still result in double keying of data until SSTS retired.	• New Business System incorporating eESS, Payroll and linking to Optima is being procured as part of wider NHS Digital Transformation.
• Maternity/Paediatrics/Neonatal	• Unable to move service onto SafeCare as yet as this does not capture the descriptors for the specialised areas involved.	• Continue to work with HIS and local eRoster Team to ensure that SafeCare can be fully implemented with accurate descriptors.
• Community Midwifery	• Long Term Sickness absence and unfilled vacancies have led to homebirth service being paused currently.	• Focus on delivery of essential care within community midwifery. • Continue active recruitment to vacancies.
• Theatres and ITU	• Increased Dependency Levels - Higher acuity case mix creates pressure on nurse-to-patient ratios and real-time decision-making.	• Use of SafeCare and RTS to identify staffing risks and support case for recruitment.
• GP and OOH Service	• Variable completion of real-time staffing tools during periods of service pressure - High clinical demand can limit staff capacity to consistently complete SafeCare entries during every shift, creating a risk of under-reporting staffing pressures and impacting full compliance with Duty 12IC.	• Managers and staff to consider ways of increasing completion of real time staffing assessments to reflect clinical staffing pressures.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12ID: Duty to Have Risk Escalation Process in Place.

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the escalation of any risk.** (a) identified during the real-time assessment of its staffing levels in accordance with arrangements put in place under section 12IC, and (b)which it has not been possible to mitigate in accordance with the arrangements put in place under that section. **(2) The arrangements under subsection (1) of this duty must include:** a) A procedure for the initial reporting of a risk as described in subsection (1), by an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, to a more senior decision-maker, b) A requirement for any such decision-maker to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it, c) A procedure for the onward reporting of the risk, as necessary, to a more senior decision-maker in turn, and a requirement for that decision-maker in turn to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it, d) A requirement for the arrangements put in place under paragraph (c) to escalate further in order to reach a final decision on the risk, including in appropriate cases by the reporting of the risk to the members of the Health Board. e) A procedure for the notification of every decision made following the initial report, and the reasons for it, to: (i)any individual who was involved in identifying the risk in accordance with the arrangements put in place under section 12IC(2)(a), (ii)any individual who was involved in attempting to mitigate the risk in accordance with the arrangements put in place under section 12IC(2)(c), (iii)any individual who was involved in reporting the risk in accordance with the arrangements put in place under paragraph (a), (c) or (d) of this subsection, and (iv)any individual who gave clinical advice in accordance with the arrangements put in place under section 12IC(2)(c), or under paragraph (b), (c) or (d) of this subsection, f) A procedure for those individuals to record any disagreement with any decision made following the initial report, g) A procedure for those individuals to be able to request a review of the final decision on a risk (other than a final decision made by the members of the Health Board or the Agency) made in accordance with the arrangements put in place under section 12IC(2)(c) or, as the case may be, paragraphs (b), (c) or (d) of this subsection, h) Raising awareness among staff about the procedures described in paragraphs (a) to (f),

	i) Training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of healthcare, and other senior decision-makers, in how to implement the arrangements put in place under paragraphs (a) to (h), and j) Ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12ID.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- All clinical areas report having a risk escalation process in place, albeit that some of these are informal due to lack of documentation to support the process but with increasing numbers of SOPs being developed.
- Initial risk escalation is either through Safety Brief/Safety Huddles or directly to line managers if safety issues are not identified until after these huddles due to staggered shift times and late notice absences.
- Those clinical teams without a formal risk escalation process in place are reviewing their processes particularly where TURAS RTSRs and SafeCare are not seen as a good fit for the service. Several areas report having Business Continuity and/or Contingency Plans that they follow.
- The use of TURAS RTSR and SafeCare allow for recording of escalations along with details of who the risk was escalated to, although an additional step is required to convey the escalation either by phone (bleep) or email to designated line manager.
- Many clinical areas also report risks, in the form of near misses, via InPhase Adverse Incident Reporting System (although Risk & Safety Team suggest risks should be raised via RTSRs/SafeCare or local arrangements with InPhase being used to report adverse events as a result of staffing risks).
- Within Primary & Community Services a daily log, housed in SharePoint is used to identify any staffing risks and to record the escalation of those risks. Within School Nursing and Health Visiting there is a clinical judgement record stored alongside the daily staffing register. Any gaps are recorded here and escalated to the PACS Management for clinical judgement and cover arrangements. Adverse events are recorded via InPhase when staff are unable to complete work due to insufficient staffing.
- A clear and comprehensive escalation structure is illustrated in the AHP staffing risk escalation plan – enabling bi-directional information to flow between B7 team leads, clinical lead, service lead, AHP Associate Director and NMAHP Director.
- There is an established system in the 'out of hours' period - there are designated senior clinicians or managers to whom escalations can be made across the Board. There is always a Site & Capacity Manager on duty throughout the 24hr period who is a senior registered nurse and who can provide support for initial escalations. All senior clinicians/managers are identified via a published daily updated 7-day planner covering all professions.
- Ongoing staffing risks are also escalated through CMT/SMT meetings, clinical governance routes and where unmitigated, are identified on the Risk Register.

- New/enhanced services – Hospital at Home and Home First – are in process of approving Safe Staffing Risk Assessment and Escalation SOPs and are transitioning to Optima Health Roster/SafeCare.
- Longer term staffing shortages or staffing that has impacted patient care or staff wellbeing is recorded on a risk assessment in areas such as acute oncology.
- As NHS Borders is a small organisation, escalation can occur from front line services direct to the Board level clinicians relatively quickly and easily. This can happen by mutual agreement even when individuals are not formally on call, in the event that a non-clinical manager and the site and capacity manager being unable to resolve issues.
- In Mental Health, the risk escalation process is clear and well understood. The escalation from the Nurse in Charge through SCN/TM, to On-call Manager, to service manager, to ADoN/General Manager proportionate to the risk identified is effective not least because it has fostered a culture based on mutual trust and understanding of the process.

Please provide Information on your methods of monitoring compliance with Duty 12IC

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- Increasing use of SOPs to guide staff on escalation of risks. Most often the first step in the escalation process is to discuss with line managers with further escalation through the line management structure.
- Regular discussion with staff at Safety Brief/Safety Huddles and documentation of risks escalated.
- Review of RTSR and Optima eRoster/SafeCare escalations and documented mitigations and responses.
- Training clinical leads during presentations on Staffing Level Tools and Common Staffing Method.
- Review of use of SafeCare by eRostering Team with feedback to relevant managers.
- Review of InPhase reports on staffing related events both by Risk & Safety Team and by Clinical Management Teams.
- Review of Risk Register by senior management team.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, senior decision-makers in paediatric nursing were identified and a chain of escalation communicated to all personnel. Individuals are now much better aware of who to contact during any	This should describe how the success, achievement or learning could be used in the future. For example, the procedures for identifying the chain of escalation that were used in paediatric nursing are now being trialled and rolled out across other areas

	particular shift in the event that a risk needs to be escalated.	
• Increasing number of areas now using TURAS RTSRs or Optima eRoster and SafeCare	• Increased ability of staff to document escalation of risk and to have mitigations and responses documented with option of further escalation as required.	• Shared learning across teams e.g. in development of Escalation SOP • High level discussion between professional leads at HCSA Programme Board with cascade good practice to team leads and staff.
• Effective use of InPhase Adverse Event Reporting System to highlight near misses, delayed care or safety events related to staffing levels.	• Reports can be generated from InPhase to show trends/type/frequency of reported incidents – reviewed by H&S Team as well as Topic Specialists.	• Review of risks reported during monthly Clinical Management Team Meetings with feedback to managers on additional escalation activities required.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with ensuring relevant individuals involved in reporting, mitigating, escalating, or giving clinical advice on a risk are notified of decisions made and the reasons for them.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in notifying relevant individuals about decisions made and the reasons for them, what measures have been put in place to ensure this happens, such as providing training, increasing awareness and auditing to identify root causes?
• Variety of methods to assess staffing in Real Time.	• Lack of standardisation of process used to assess staffing in real time and therefore escalation processes can also vary.	• Discussion with all staff involved to ensure that they are escalating any issues at Safety Briefs/Staffing Huddles.
• Some areas continue to have informal processes of risk escalation.	• Potential lack of documented evidence of risk escalation, clinical advice sought or given and notification/feedback on decisions made. • Limited traceability and auditability of informal and especially verbal escalations.	• Meetings held widely with staff groups by Senior Nurse Workforce Planning • Attendance by ADoN (Corporate) and Senior Nurse Workforce Planning at Clinical Board Meetings to raise awareness of duties of the

		legislation and to highlight responsibilities and accountability. • Continued roll out of SafeCare will increase ease of recording risk escalations.
• GP and OOH service	• Reliance on informal knowledge and legacy processes rather than consistently updated SOPs -	• Prioritise the review and refresh of escalation and staffing-related SOPs to ensure they accurately reflect current practice, systems, and responsibilities, and clearly align with the Duties of the Act. This will support staff understanding, consistency of escalation, and evidence compliance during internal and external assurance processes

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IE: Duty to have arrangements to address severe and recurrent risks.

Duty Summary	**Duty to have arrangements to address severe and recurrent risks.** **(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements to—** (a) collate information relating to every risk escalated to such level as the Health Board or the Agency (as the case may be) consider appropriate in accordance with the arrangements put in place under section 12ID (2), and (b) identify and address those risks which are considered to be either or both— (i) severe, (ii) liable to materialise frequently. **(2) The arrangements under subsection (1) must, in particular, include a procedure for—** (a) the recording of a risk as described in subsection (1)(b), (b) the reporting of any such risk, as necessary, to a more senior decision-maker, including in appropriate cases to the members of the Health Board or the Agency (as the case may be), (c) the mitigation of the risk, so far as possible, and a requirement for appropriate clinical advice to be sought and had regard to in carrying out such mitigation, and (d) the identification of actions to prevent the future materialisation of the risk, so far as possible.

Please provide information on the steps taken to comply with Duty 12IE.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- All areas report being able to identify severe and recurrent risks through review of Turas RTSRs, SafeCare Red Flags, issues raised at Safety Briefs and Staffing Huddles, Opel reports as well as compliance with Clinical Quality Indicators, audits and reviewing complaints and feedback from service users and staff. One example is the use of a Decision-Making Log held on SharePoint within PACS.
- InPhase reports can be viewed by clinical leads and managers and are reviewed to enable learning to take place and put in place measures to address existing or emerging risks. Topic specialists also review adverse events and provide additional support and guidance to prevent recurrence.
- Mitigations, where possible, are put in place but any unmitigated serious risks are discussed in Clinical Governance Meetings and may be placed on the Corporate Risk Register. Recurring risks would also be discussed at performance reviews in MHLD and other P&CS divisions.
- The national risk assessment matrix is used to identify the severity and likelihood of risks occurring so that appropriate action can be taken.

Please provide Information on your methods of monitoring compliance with Duty 12IE

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance. • Review of risks is part of agenda at monthly CMT meetings. • The Clinical Governance team participate in the review of complaints, commendations, and assist teams with reviewing any adverse events that occur e.g. using SAERs, Medication Review Tool, Pressure Damage Review Tool etc. • Sharing of learning around risk is encouraged and training on risk management is provided for all Clinical Leads by the Risk and Safety Team. • Enduring risks placed on risk register, discussed at Clinical Board Meetings and taken to the Operational Planning Group with severe/recurring risks highlighted to the Executive Team.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, a recurrent risk was identified in the capacity of one laboratory, leading to a delay in testing samples and communicating sample results. Following investigation, the process for booking in samples was streamlined and an admin coordinator was appointed. This has improved performance, and the lab is now meeting its targets.	This should describe how the success, achievement or learning could be used in the future. For example, the organisation is now looking at whether the changes implemented in one lab could be applied to other labs, to improve wider performance.
All clinical areas	• Environmental risk assessments are conducted and reviewed for any impact that these may have on staff or patient safety and welfare.	• Sharing of information across the organisation where risks have been identified in order to prevent such future materialisation.
Topic Specialists	• All adverse events and near misses are reviewed by managers with significant incidents or risks reviewed by Topic Specialists to provide advice on prevention of further risk.	• Close working between Topic Specialists within Risk, Health & Safety and risk reviews undertaken by Clinical Governance staff to enhance learning from risk assessment and management.

Mental Health Teams	• Implementation of learning improvement plans following identification of severe/recurring risks.	• Concept of learning improvement plans to be shared and used by wider clinical teams across NHSB.
Clinical Governance Team	• Involved with review of all complaints, commendations, and feedback to clinical services. • Review any adverse events that occur using SAERs, Medication Review Too, Pressure Damage Review Tool etc.	• Sharing of good practice across the Board • Identification of learning opportunities and quality improvement activities to prevent further materialisation of risks and events.

Public Dental Services	• Strong governance framework (InPhase, Risk Register, OPEL).
	• Recurring themes identified through:
	  ○ Dental Dashboard
	  ○ Operational Group
	  ○ Clinical Board
	  ○ Patient safety reviews
	• Proactive identification and escalation of repeated staffing pressures
		• Share processes used for trend analysis, escalation, and mitigation with other services through discussion at Programme Board.

Radiology	• Recurrent risk of staff working excess hours on call was addressed through OPG and BET. • Workforce review undertaken which highlighted the need for 5 WTE to allow all hours delivered by Radiology to be within contracted hours. Following a successful recruitment process of 5 Radiographers (August 2025) and a 3-month induction programme, the new shift pattern was implemented in November 2025. Staff no longer work more than their 37 hours per week per rata.	• Consider how learning from workforce review could be shared with other similar services who are required to work on call patterns.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action

This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, collation of information in a particular NHS function has identified a risk that materialises frequently, however identification of actions to prevent future materialisation has not improved the situation.	This should describe what actions have been / are being / will be taken to address the situation. For example, if identification of initial actions to prevent a recurring risk has not improved the situation, further steps may include establishing a working group to investigate and make recommendations, observing practice in the area, interviewing staff, addressing the staff skills mix, allocating additional assistance, redesigning the service etc.
Clinical Teams in Acute Services	• Difficulty in releasing staff for full Risk Assessment and Management Training due to workload pressures. • Risks not always reviewed as quickly as they should be due to time pressures and lack of protected leadership time.	• Risk & Safety Team to collaborate with teams at ward/department level to assist with assessment, review, and management of risk. • Teams to identify ways of protecting leadership time. • Risk & Safety Team and Topic Specialists continue to highlight and review most serious or enduring risks identified on InPhase/Risk Register.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IF: Duty to Seek Clinical Advice on Staffing.

Duty Summary	**Duty to Seek Clinical Advice on Staffing.** **(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for—** (a) seeking and having regard to appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing under sections 12IA to 12IE and 12IH to 12IL, (b) recording and explaining decisions which conflict with that advice. **(2) The arrangements under subsection (1) must, in particular, include—** (a) where a Health Board or the Agency (as the case may be) reaches a decision on a matter which conflicts with the clinical advice it has received— (i) a procedure for the identification of any risks caused by that decision, (ii) a procedure for the mitigation of any such risks, so far as possible, (iii) a procedure for the notification of any such decision, and the reasons for it, to any individual who gave clinical advice on the matter, (iv) a procedure for any such individual to record any disagreement with the decision made on the matter, (b)a procedure for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the Health Board or the Agency (as the case may be), on at least a quarterly basis, about the extent to which that individual considers that it is complying with the duties imposed by— (i) this section, and (ii) sections 12IA to 12IE and 12IH to 12IL, (c) a procedure for such individuals to— (i) enable and encourage other employees to give views on the operation of this section, and (ii) record such views in reports made in accordance with the arrangements put in place under paragraph (b), (d) raising awareness among individuals with lead clinical professional responsibility for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (c), and (e) ensuring that such individuals receive adequate time and resources to implement those arrangements.

	(3) Every Health Board and the Agency must have regard to the reports received in accordance with the arrangements put in place under subsection (2)(b).

Please provide information on the steps taken to comply with Duty 12IF.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- Compliance with this duty continues to be challenging as many areas have been used to seeking advice informally and without any documentation to support it. Generally clinical advice is sought through line management structures in the first instance.
- Use of TURAS RTSRs and Optima eRoster/SafeCare enable the identification of the person giving advice and this level of detail is then documented.
- Daily during Safety Brief and Staffing Huddles in Acute Services, an escalation and decision-making sheet is used to document staffing risks raised and is completed with a record of advice given, by whom and actions taken. Work is ongoing to ensure that this process is consistently robust.
- Within Primary & Community Services a SharePoint decision making log is used by all teams.
- The first port of call for clinical advice on staffing in the Out of Hours period is the Site & Capacity Manager who is a senior nurse.
- A 7-day planner is updated daily to document a record of senior staff available in each profession who can be contacted for advice and guidance throughout the 24hr period.
- Where an on-call manager is nonclinical, they can refer to the Site & Capacity Manager if required, but locally mechanisms for contacting clinical colleagues are also made available.

Please provide Information on your methods of monitoring compliance with Duty 12IF

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- Each day there is a follow up discussion of any advice given so that it can be identified if this was sufficient and appropriate, if there were any conflicts between advice given and actions taken and to ensure that all concerns are acted upon appropriately, with feedback to staff.
- Decision making logs are used to document advice given and actions taken.
- Currently any conflicts would be managed via Records of Discussion, documentation in patient notes or via InPhase adverse incident reports if any incidents or near misses were to occur as a result of advice received/actions taken. To date there have been no reported incidences of conflicts occurring.
- The implementation of SafeCare will support the recording and evidencing of clinical advice having been sought and the subsequent outcome of that advice, including any disagreement with the advice provided. This will also support the provision of feedback to the person who escalated the risk. Voiced concerns of patients and relatives can also be recorded on SafeCare.

- The issue of Clinical Advice (seeking and documenting including any conflicts) is part of Safe Staffing Risk Assessment and Escalation SOPs already developed or currently in development.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, the views of employees included in the reports prepared by individuals with lead clinical professional responsibility for a particular type of healthcare identified a potential improvement in working practices in one area.	This should describe how the success, achievement or learning could be used in the future. For example, the potential improvement is being trialled in the one area and if successful will be rolled out across other areas in the organisation.
All professional groups	• A 7-day planner is available for all clinical professions in the out of hours period detailing who to contact for clinical advice. • The small size of the Board enables rapid escalation of issues and also facilitates informal means of accessing the advice of colleagues even in the out of hours period if an on-call manager is nonclinical.	• Need to ensure that services have SOP to inform process to be followed for obtaining and recording clinical advice as well as process for documenting any conflicts between advice given and action taken.
Increasing use of TURAS RTSR and Optima eRoster/SafeCare	• Increase in consistency in how clinical advice and any conflicts with this are documented.	• Continue roll out of Optima eRoster/SafeCare according to trajectory will facilitate auditing of compliance with this duty.
No conflicts with advice identified to date.	• Good engagement between clinical staff and managers using collaborative and respectful dialogue.	• Identification of method of recording any conflicts which is consistent within NHSB.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, in compiling reports made to the members of the Health Board, there are good mechanisms in place for the Medical Director to enable and encourage medical employees to give their views, but the mechanisms for seeking the views of other professional groups for which they are responsible, such as pharmacy employees, are not well established. Hence, the views of these employees are not being sought or incorporated into the reports.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the views of all professional groups are not being sought, what measures have been put in place to engage these groups and proactively seek out their opinions.
All Professional Groups	• There needs to be ongoing improvement to the documentation of advice sought and received along with any conflicts identified and teams are working on the processes most effective for their service/department	• Use of SBAR • Development of SOP to provide clarity.
All Professional Groups	• Feedback loops need to be strengthened across the Board to ensure that decisions made when staffing risks are identified are fed back and explained to the individual raising the concern.	• Ensure that the issue of Clinical Advice (seeking and documenting including any conflicts) is part of Safe Staffing Risk Assessment and Escalation SOPs already developed or currently in development.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IH: Duty to ensure adequate time given to clinical leaders.

Duty Summary	**In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties, including, in particular, time—** (a) to supervise the meeting of the clinical needs of the patients in their care, (b) to manage, and support the development of, the staff for whom they are responsible, and (c) to lead the delivery of safe, high-quality, and person-centred health care.

Please provide information on the steps taken to comply with Duty 12IH.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- All professions report having a system of time given to Clinical Leaders to carry out their leadership activities, however there is not consistent application of resource across and within services.
- All clinical leads maintain close working with the teams for whom they are responsible in order to support the development of staff.
- Within Acute Nursing there has been a recent move to introduce a second B6 Charge Nurse in several wards to assist with leading the delivery of safe, high-quality, and person-centred care.
- Flexibility and autonomy are afforded to many clinical leaders to manage their own diaries and to use their time according to their leadership responsibilities e.g. Dentistry, Pharmacy, some AHP, Audiology.
- Service reviews, workforce planning activities and the use of Staffing Level Tools/Common Staffing Method (for those covered by Duty 12IK) enable an assessment of leadership time with scope to redesign workload/workforce where possible.
- Medical staff use job planning to ensure that training and development requirements can be met.

Please provide Information on your methods of monitoring compliance with Duty 12IH

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- The utilisation of TURAS RTSRs and Optima eRoster/SafeCare enables closer monitoring of the times when clinical leadership time is lost due to mitigating staffing shortages.
- Escalations on both systems enable leads to document the number of times that their leadership time is lost to clinical caseload holding.

- Daily Safety Brief in Acute and the Safety Huddles held within Primary and Community Services enables the documentation of the amount and frequency of lost leadership time across services.
- Clinical Quality Indicators are reviewed to assess the quality and safety of patient care delivery in specific clinical areas and to highlight where leadership may be lacking.
- Other KPIs including sickness absence management, allocation of CPD time and the completion rate for appraisals are also indicative of whether leadership resource requirements are being achieved.
- Discussion of all of the above, where risks are identified, takes place at monthly CMT meetings as well as during Staff and Clinical Governance Meetings.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, senior physiotherapists and team leaders convened a working group to determine what sufficient time and resources would look like for individuals with lead clinical professional responsibility for a team of staff. The outcome of the project w. as a determination of time and resources for different team leaders, and feedback so far has been positive.	This should describe how the success, achievement or learning could be used in the future. For example, the positive outcome experienced as a result of the working group has led to this model being extended to other AHP areas and trialled to see applicability.
• Acute Adult Nursing	• A trial is currently underway in Acute Nursing to give full supervisory status to Senior Charge Nurses to enable them to achieve leadership responsibilities.	• There are signs of improvements to management of sickness absence, appraisals undertaken and provision of training and development in areas where the supervisory status has been sustained.
• Women & Child Health	• Support for 12 months for SCM's within BGH & Community to be supervisory (Paediatrics/Neonates already have this embedded).	• Share staffing model across other services to allow similar implementation of leadership time.

• Dentistry, Pharmacy, Medicine, Psychology, AHP and Audiology.	• Within a number of professions, the time given to Clinical Leaders is either worked into Job Plans (Medical and some AHP staffing as well as Psychology) or Clinical Leads are facilitated to work flexibly and have autonomy to diarise the time required for leadership activities to meet their individual needs.	• Look at rolling out Job Plans to other professions • Review of Job Descriptions as part of Service Reviews. • Formal identification of time for clinical leadership on a fair and equitable basis across the organisation.
• Supervision	• Clinical supervision is used in some areas e.g. Mental Health, District Nursing which helps to identify the specific time requirements of individual leads depending on experience, size, and composition of teams. • Professional supervision as per HCPC guidelines is provided 4-6 weekly for AHPs.	• Consider roll out of Clinical/Professional Supervision for all professions to enable clear articulation of clinical leadership time resources.
• Health Visiting	• An external Peer Review of NHS Borders Health Visiting Leadership structure is about to be commissioned.	• Learning from Peer Review to be shared with other disciplines.
• GP and OOH Service	• Protected non-clinical time is built into rotas for clinical leadership roles, supporting Duty 12IH. The multidisciplinary staffing model (GPs, ACPs, NPs, paramedics, drivers, and reception staff) enables flexibility in staffing and contributes to safe service delivery across out-of-hours periods.	• Consider how similar approach could be adopted by other multidisciplinary teams.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, the process in place to identify the roles, and therefore individuals, with lead clinical professional responsibility for a team of staff does not consistently identify who these individuals are,	This should describe what actions have been / are being / will be taken to address the situation. For example, if the process in place to identify the roles, and therefore individuals, does not consistently identify who those individuals are, what measures have been taken to address this?

	and therefore sufficient time and resources for these individuals to discharge their responsibilities has not been considered.	This could involve collaborating with all staff groups, clinical areas, and teams to identify job titles / roles, utilising HR processes, and information and or utilising eRostering to identify team leaders etc.
• Inconsistent application of this Duty across and within professions in NHS Borders.	• There is a requirement for greater consistency of application of time given to Clinical Leaders and to ensure that professions take account of this during workforce planning and service reviews	• Calculation of time required by clinical leads in all areas to be part of workforce planning and job planning activities across every specialty.
• Reduced Working Week	• Where funding is not made available for backfill or where recruitment challenges exist the reduction in working hours has potential to further impact on the time available to clinical leaders.	• Team Leads to work with line managers to identify ways of protecting leadership time or accessing additional funding.
• Almost without exception clinical leaders report being unable to consistently achieve the amount of clinical leadership time required of their role.	• There remain concerns that Clinical Demand at times leads to deprioritisation of leadership time with these individuals providing the safety net when workload or staff absences increase at short notice. This commonly occurs within Nursing, Healthcare Scientists (Labs and Physiological Medicine Department), and Pharmacy as well as across AHP services.	• During Job Planning, Workforce Planning, and appraisals there is a need to identify an accurate calculated leadership time required by individual clinical leaders according to their unique remit
• Across Nursing & Midwifery Teams there remains variation in approach to allocation of leadership time for clinical leaders.	• Some departments e.g. ITU, Theatres, Labour Ward, and Child Health SCNs are 100% supervisory. Some Community Nursing Teams use 1:1 meetings with managers as well as appraisals and reviewing KPIs to identify an adequate level of time for clinical leadership activities.	• QI methodology being used to demonstrate value of supervisory status for leadership, safe, high quality, and person-centred care within Maternity Services. This may be shared and replicated across other services once audited. • Performance measures which are discussed within Clinical Management and Clinical Governance meetings can guide allocation of leadership time requirements.
• Palliative Care	• Nurse Consultant who has both Strategic and Clinical responsibilities has to assume management role due to having no operational team lead in post/funded.	• Use SLT outputs and Common Staffing Method to illustrate accurate staffing and leadership requirements.

• Small Teams	• Covering a 24/7 service with a small staff group, it is not always been possible to protect time for senior staff e.g. in Labs, whereby leadership time becomes an ad hoc arrangement due to providing first line mitigation in times of short staffing.	• Use of Service Reviews and Workforce Planning to identify actual staffing requirements. • Consider further cross boundary regional working e.g. for on call advice.
• Nursing Teams in Acute	• Completion of Appraisals consistently low.	• Protected leadership time to enable meaningful 1:1 discussion between line managers and staff to identify personal development needs.
• Multiple professional groups	• Sickness absence levels consistently above 4% national target. • Lack of robust management of sickness/absence.	• Targeted assistance from HR with monitoring and managing sickness absence. • Shared learning from teams that manage sickness absence within target levels with those showing highest levels.

COMPLIANCE ASSURANCE LEVEL
Limited Assurance

Duty 12II: Duty to ensure appropriate staffing: training of staff.

Duty Summary	**In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that its employees receive—** (a) such training as it considers appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b), and (b) such time and resources as it considers adequate to undertake such training.

Please provide information on the steps taken to comply with Duty 12II.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- Organisationally there is a Corporate Training Plan moving through development, outlining training requirement for all staff based on professional or service needs as identified at department/service level.
- Learning Plans are recorded on LearnPro/CARS or TURAS.
- Training and Development is provided both in face-to-face classroom settings and online E-Learning platforms.
- Simulation Training Suite is used for a variety of simulated training scenarios.
- Training & Education Development (TED) Board has oversight of Training and Education opportunities and can distribute funding for specific courses/learning opportunities if applications are agreed by the Board.
- GDC registration is confirmed annually and Retention of Radiology Entitlement Documentation for all dental registrants makes compliance more robust. Likewise, IRMER legislation leads to greater compliance with training for radiography staff.
- All staff have direct access to educational programmes including Clinical updates, compassionate care, QI Academy but ensuring staff release remains challenging particularly for frontline staff.

Please provide Information on your methods of monitoring compliance with Duty 12II

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- NHS Borders has a compliance target of 95% for mandatory training which is monitored by the Clinical & Professional Development Team and a report is published monthly for SCNs/Team Leads' awareness.
- All training and development metrics are discussed at monthly Clinical Management Team meetings.
- Introduction of suite of 'Once for Scotland' statutory/mandatory training modules should help NHSB to be more consistent with other Boards and to compare trends.
- Use of training plans across all services which can be reviewed for levels of achievement by managers and during staff appraisals.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, the psychology department in conjunction with HR, has just completed a project to promote more accurate capturing of information relating to continued professional development for psychology colleagues. Feedback from employees is that they have found the new system much easier to use and are now recording relevant CPD.	This should describe how the success, achievement or learning could be used in the future. For example, AHP colleagues have now expressed interest in the new system and are undertaking a project to establish whether they could implement something similar.
Across all areas – Agenda for Change Staff	• Budgets have 2% built into their Predicted Absence Allowance attributed to training and development. • Some areas e.g. Mental Health have remodelled their budgets to include higher level of PAA for training and development activities.	• Learning from Mental Health can be shared with other clinical boards/services to share good practice and identify innovative ways of increasing funds available for training.
Clinical & Professional Development Team	• The C&PD team are very responsive to specific needs identified within clinical areas and will provide targeted training at team level and in clinical settings where release of staff is challenging.	• Continuing examination of innovative ways to train staff and ensure maximum staff and patient safety.
Clinical & Professional Development Team	• Monitor compliance with statutory training and only accept applications for additional training where an individual has achieved 100% compliance.	• Awareness of importance of statutory and mandatory training and development compliance is shared across the organisation.
Medical, Dentistry, Psychology	• Job Planning utilised to identify training and development needs and time commitments.	• Roll out of job planning to some other professions where this would be achievable and beneficial.
Theatres and Intensive Therapy Unit	• Establishment of Clinical Educator posts within the departments to ensure that staff competencies are achieved.	• Other clinical areas can share learning and consider ways that similar posts might be funded and established.

Mental Health	• 6% of budgets is allocated to training and development of staff. All parts of the service undertake appraisal and personal development planning.	• Share ways of modelling budget to increase availability of training resource. • Continue to look at ways of ensuring inpatient areas can accommodate training as well as community colleagues do.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, clearly defined processes and procedures exist for some groups of staff, e.g. nursing and midwifery, but do not exist for other groups of staff, e.g. healthcare scientists.	This should describe what actions have been / are being / will be taken to address the situation. For example, if procedures and processes are not in place for healthcare scientists, please list the measures which need to be put in place to address this, such as working with HR and healthcare scientist representatives to define an appropriate training programme, assess training needs of employees and plan for required training to be undertaken.
Agenda for Change Staff	• Budget for training and development set at 2% and is almost always considered inadequate.	• Need for review of training plans to be completed with realistic and achievable goal setting.
All professional groups	• Statutory and Mandatory training compliance falling short of 95% target	• Professional leads working with Clinical & Professional Development and managers to identify resource requirements for specific departments. • Risk associated with Training & Development compliance placed on Risk Register. • Recommended that each Clinical Boards' compliance rates be formally included in their relevant governance meetings for example, Clinical Management Team meetings, Hospital

		Management board and Clinical Governance Reports. This will help maintain visibility, foster a culture of continuous improvement, and reinforce the importance of mandatory training across all areas.
All professional groups	• Appraisal & PDP completion rates are suboptimal resulting in individual training and development needs not being identified or met.	• Trajectory and planned schedule of appraisal and PDP to be prioritised each year to enable better management of processes and identification of training requirements.
All Agenda for Change Clinical Staff	• Protected Learning Time part of previous non pay element of pay award not fully achieved.	• Need for steer from Scottish Government as to how this protected time can be resourced and achieved.
Urgent Care and Medicine	• Vacancies lead to staff having to undertake role mandatory training in own time.	• Active recruitment to vacancies and ongoing workforce planning. • Managers to continue to consider ways in which staff can be released for training and development within current resources to foster staff wellbeing and good work/life balance.
Mental Health Services	• The move to 12-hour shifts has significantly reduced overlap time for on-ward (inpatient) learning. Numbers able to attend individual learning sessions are small.	• Continue to work with a dedicated MH resource in training and education department who supports staff to attend training and where deficits are identified finds resources to complete.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IJ: Duty to follow the common staffing method.

Duty Summary	**(1)In relation to health care of a type mentioned in section 12IK, a Health Board or the Agency (as the case may be) must, no less often than at the frequency specified in regulations by the Scottish Ministers, use the common staffing method set out in subsection (2).** **(2) The common staffing method means that a Health Board or the Agency (as the case may be)—** (a) uses the staffing level tool and the professional judgement tool as prescribed in regulations under subsection (3) and takes into account the results from those tools, (b) takes into account, in so far as relevant, any measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H (1) by the Scottish Ministers (including any measures developed as part of a national care assurance framework), (c) takes into account— (i) its current staffing levels and any vacancies, (ii) the different skills and levels of experience of its employees, (iii) the role and professional duties, in particular, of any individual with lead clinical professional responsibility for the particular type of health care, (iv) the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care including, in particular, those to which this section does not apply, (v) the local context in which it provides health care, (vi) patient needs, (vii) appropriate clinical advice, (viii) any assessment by HIS, and any relevant assessment by any other person, of the quality of health care which it provides, (ix) experience gained from using the real-time assessment arrangements under section 12IC (1) and the risk escalation processes under sections 12ID and 12IE, (x) comments by patients, and by individuals who have a personal interest in their health care (for example family members and carers within the meaning of section 1 of the Carers (Scotland) Act 2016), which relate to the duty imposed by section 12IA, and (xi) comments by its employees which relate to the duty imposed by section 12IA, (d) identifies and takes all reasonable steps to mitigate any risks, and (e) having followed the steps described in paragraphs (a) to (d), decides what changes (if any) are needed as a result to its staffing establishment, and to the way in which it provides health care.

Please provide information on the steps taken to comply with Duty 12IJ.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- All areas covered by Duty 12IK that have a specialty specific Staffing Level Tool complete the Common Staffing Method once the Tool has been run. The caveat to this is that some single practitioner services may not have run Tools if there have been periods of extended absence etc.
- Triangulation of the Staffing Level Tool output together with the Professional Judgement Tool output (and where applicable the Quality Tool results) takes place.
- The above information is then set against the background of local context and addresses issues such as Funded Establishment, Actual Staffing numbers, Vacancies and position of recruitment process, Sickness Absence and review of all KPIs and Clinical Quality Indicators relevant to the area to identify and address quality and safety issues that might be existing or emerging
- Each Staffing Level Tool runs for a minimum of 2 weeks in the financial year in accordance with HCSSA 2019 mandate.
- From October 2025 the MHLD Tool has been housed in SafeCare and removed from SSTS whilst the refreshed Professional Judgement Tool remains on the SSTS platform. The first run of the MHLD Tool on SafeCare was run for two weeks commencing 2 Feb 2026 with raw data files submitted to HIS for reporting back to Board on recommended whole time equivalent staffing requirements.
- Since 30 Oct 2025, the revised Professional Judgement Tool on SSTS has been used concurrently with any Staffing Level Tool and appropriate training and support has been provided by the Senior Nurse Workforce Planning using the HIS Staffing Level Toolkits.
- We are participating in the development of the Community Mental Health workload tool. Staff recognise the multi-disciplinary nature of their safe staffing model and will evaluate the Community model against this.

Please provide Information on your methods of monitoring compliance with Duty 12IJ

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- The findings from use of the Common Staffing Method are discussed between clinical leads, clinical/service or general managers +/- finance representatives and an Executive lead. This governance process allows for outputs of tools and findings from CSM to be included in Service Reviews and Workforce Planning activities.
- Care Assurance Inspections have been introduced locally using Excellence in Care framework - these visits involve clinical leads and managers speaking with staff from all disciplines involved in the area of care provision, to discuss the safety and quality of care delivered and the responsibilities of individual staff under the HCSSA legislation. The elements of these inspections align closely to the Common Staffing Method.
- There has been ongoing support from Senior Nurse Workforce Planning for Clinical Leads preparing their Common Staffing Method reports and retrieving appropriate data.

- The Senior Nurse Workforce Planning liaises with colleagues nationally and with HIS to highlight any issues with the tools and to seek explanations/guidance or solutions.
- The multiple strands of the Common Staffing Method can facilitate a robust review of staffing and can be used by teams who do not fall under Duty 12IK.
- As other Staffing Level Tools transition to SafeCare (Maternity, ECP and Neonatal Tools initially) the eRostering Team will collaborate with Senior Nurse Workforce Planning and Team Leads to ensure that data can be obtained to generate rWTE to inform Common Staffing Method reports.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, application of the common staffing method in adult inpatient provision identified some areas where the staffing establishment needed to be changed, and some areas with potential for service redesign. These changes are now in progress and will be trialled to monitor the outcomes.	This should describe how the success, achievement or learning could be used in the future. For example, following completion of the trials regarding changes in staffing establishment and service redesign, decisions will be taken about their formal adoption. A summary of this exercise could then be used as case studies to inform training for staff about the use of the common staffing method.
Agreed schedule of Staffing Level Tools to be run for 2 weeks each year as mandated by HCSSA 2019 (although teams can engage in additional Tool runs if they wish).	• All clinical teams know in advance when they are scheduled to run their Staffing Level Tool and subsequently to provide their Common Staffing Method reports. • Standard Operating Procedure established for the running of the Common Staffing Method. • All CSM reports follow a governance process to enable decisions to be made regarding changes to staffing establishments where needed.	• The use of robust Common Staffing Method reports can assure managers that all relevant data has been considered in identifying altered staffing requirements. • Shared learning across teams and services to identify best practice in use of CSM and training requirements. • National Expert Working Group recommendations will be adopted locally.
Common Staffing Method can provide useful framework for discussion by teams not covered by Duty 12IK.	• Discussion with teams as to whether they can adopt the Common Staffing Framework for clinical staff assessment and decision making e.g. Team lead for Continence Nurses signed off CSM for that	• Support given to any clinical team by Senior Nurse Workforce Planning to facilitate adoption of CSM framework (without Staffing Level Tool outputs) for clinicians not covered by Duty 12IK.

	team after application of CNS Tool but recognised that this would be a useful framework for physiotherapy colleagues to use.	
Acute Nursing Services	• Adult Inpatient Tools and subsequent Common Staffing Method Tool reports being used by ADoN (Corporate) as part of audit of projected nursing requirements.	• Consideration of Tool output rWTE figures together with Professional Judgement outputs and other data such as trends in patient presentation numbers, acuity etc will be ongoing part of nursing establishment reviews.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, the common staffing method was followed at the required frequency in all areas except emergency care provision with an explanation of why this was not completed, e.g. lack of knowledge / training of personnel.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the common staffing method was not followed in emergency care provision and this was due to lack of knowledge / training, what measures were put in place to address this, e.g. identifying key personnel, provision of training, assistance from experienced personnel in other areas etc.
Some Staffing Level Tools requiring refresh and/or redevelopment.	• Tools are at times showing rWTE figures that may be inaccurate – in part due to calculator development which is still being reviewed nationally by analysts and partly due to the workload of areas changing significantly since the observation studies done to inform the development of current staffing level tools.	• Close collaborative working with national colleagues at HIS and analysts to identify any issues, attempt to resolve issues and to address inconsistencies in outputs with sharing of findings across national teams.
Staffing Level Tools transitioning to SafeCare.	• Results may be inconsistent or inaccurate initially as teams learn how to run tools in SafeCare and	• Training sessions held by HIS and attendance by staff locally is encouraged.

	until we ensure that the raw files obtained from SafeCare contain all data required by HIS to provide reports. Any new system takes time to bed in and SafeCare remains challenging at times for teams. • Labour intensive to extract raw data files from SafeCare to send to HIS for rWTE reports.	• Support from Senior Nurse Workforce Planning • Support and ongoing involvement of eRostering Team in training staff on use of SafeCare and on pulling raw data files. • Reporting functionality being developed nationally for direct reporting from SafeCare.
Common Staffing Method reports are labour intensive.	• Clinical pressures and lack of protected leadership time render the running of Tools and in particular the collation of data for Common Staffing Method report a challenge for many clinical teams.	• Training and ongoing support from Senior Nurse Workforce Planning in preparing Common Staffing Method reports.
All groups covered by Duty 12IK	• Service reviews take place and actions may be taken without full consideration of Staffing Level Tool outputs (rWTE), Professional Judgement (rWTE), and Quality Tool outputs (where appropriate – 3Cs tools) with staffing establishment decisions being identified without available evidence.	• All Common Staffing Method reports must follow full governance structure and sign off following completion. • Greater transparency of decisions made following Staffing Level Tool Runs and completion of Common Staffing Method with increased feedback to staff.
Limitation of Staffing Level Tools	• Use of Staffing Level Tools for those areas that have them, is one part of the Common Staffing Method but cannot be viewed in isolation. Whilst use of SLTs can identify and record staffing level risks, their use alone cannot solve or mitigate risk.	• Ensure that all aspects of Common Staffing Method are fully understood by areas using the CSM. • Ensure full appreciation of the local context of care delivery alongside any SLT outputs. • Involvement of Finance to review implications of Staffing Level Tool recommendations.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IL: Training and consultation of staff

Duty Summary	**In complying with the duty imposed by section 12IJ, every Health Board and the Agency must—** (a) encourage and support its employees to give views on its staffing arrangements for the types of health care described in section 12IK, (b) take into account and use any such views it receives to identify best practice, and areas for improvement, in relation to such staffing arrangements, (c) train employees (including, in particular, employees of a type mentioned in the third column of the table in section 12IK (1)) using the common staffing method on how to use it (d) ensure that those employees receive adequate time to use the common staffing method, and (e) provide information to employees engaged in the types of health care described in section 12IK about its use of the common staffing method, including about— (i) the results from using the staffing level tool and the professional judgement tool under paragraph (a) of section 12IJ (2), (ii) the steps taken under paragraphs (b), (c) and (d)] of that subsection, and (iii)the results of its decision under paragraph (e) of that subsection.

Please provide information on the steps taken to comply with Duty 12IL.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- Prior to running a Staffing Level Tool, there is a minimum 4-week period of preparation and training for using the SLT. During Tool Runs the Senior Nurse Workforce Planning provides 'drop-in sessions' that staff can join to ask questions, troubleshoot issues and provide ongoing support.
- Senior Nurse Workforce Planning provides appropriate guidance and support to teams in the use of the tools using HIS Toolkits.
- Once tool runs are completed and data is placed on SSTS, there is discussion with the Clinical leads as to what is demonstrated in Business Objects reports and they are supported to look at all information relevant to their area as part of using the Common Staffing Method.

Please provide Information on your methods of monitoring compliance with Duty 12IL

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- Common Staffing Method SOP outlines all steps to be taken and within which timelines so that CSM reports can progress through appropriate governance in a timely manner to ensure that use of findings is relevant to decisions that need to be made regarding staffing establishments.
- Findings from tool outputs are discussed and validated and staff are encouraged to give feedback and opinions on the findings and any recommendations that follow. It must be acknowledged that staff continue to feel that feedback from Tool runs/outputs remains lacking.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, key personnel who were very experienced in using the common staffing method were engaged to train and mentor other personnel involved in the process.	This should describe how the success, achievement or learning could be used in the future. For example, those key personnel have now decided to meet regularly in a forum to discuss shared learning and to ensure the common staffing method is used consistently across all relevant areas in the organisation.
All groups of staff covered by Duty 12IK	• SOP developed outlining all timelines and steps for Common Staffing Method Tool/reporting and distributed for full consultation/comment by key stakeholders.	• SOP to be adopted in all clinical teams who currently have a Staffing Level Tool mandated for use by HCSSA 2019.
Knowledge of legislation within Clinical Boards.	• Senior Nurse (Workforce Planning) and Corporate ADoN have met with representatives from all Clinical Boards and middle management to provide greater knowledge around the legislation and the requirements placed on Boards by the HCSSA 2019 including the responsibilities of each group of staff/managers.	• Continue to provide support to Clinical Boards to ensure that Common Staffing Method is understood and used by appropriate teams to facilitate decision making around staffing establishments using all relevant data available.
Provision of staff training to all groups covered by Duty 12IK	• Due to the wide geographical location of NHS Borders clinical teams, Microsoft Teams has facilitated much greater engagement of staff to attend sessions and fully understand the ethos of the legislation and tools and the processes used as well as how findings can impact on the service they provide.	• Continue to use Microsoft Teams to reach maximum number of personnel and ensure efficient use of time by Senior Nurse Workforce Planning and increase engagement.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, issues were identified with a lack of training on the CSM for personnel in emergency care provision due to time constraints.	This should describe what actions have been / are being / will be taken to address the situation. For example, arranging and delivering training; the provision of mentoring from experienced personnel; or the adoption of job planning which ensures adequate time is available for designated personnel to undertake training on the common staffing method.
Lack of engagement by clinical teams.	• Workload pressures and time constraints frequently cited as reason for non-attendance at training sessions on Common Staffing Method.	• Senior Nurse Workforce Planning continues to deliver organised and bespoke training to teams via a mix of Teams calls, face to face meetings and written guidance.
Lack of uptake with training resources available on TURAS.	• Staff finding TURAS learn modules on HCSSA are difficult to navigate and there is a very complicated process to extract reports linked to LearnPro via CARS. Workload pressures and lack of protected learning time are also cited as reasons for low uptake.	• Managers to be encouraged to identify innovative ways to record training completed on TURAS. • Ongoing discussions between eLearning Lead locally and NES to establish more accessible reporting. • The TURAS learning modules on HCSSA 2019 have been mandated locally for nursing and midwifery staff to encourage uptake.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Planning and Securing Services

Duty Summary	**Guiding principles etc. in health care staffing and planning** (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. (2) In planning or securing the provision of health care from another person under a contract, agreement or arrangements made under or by virtue of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to— (a)the guiding principles for health and care staffing, and (b)the need for the person from whom the provision of health care is to be secured to have appropriate staffing arrangements in place.

Please provide information on the steps taken to comply with section 2(2) of this Duty.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- Certain arrangements have SG input and there is an expectation that if led by SG, there will be relevant content and checks in place.
- We have ensured that this requirement is shared with responsible officers within NHS BorderS and regular reminders will be provided.
- Given the potential non-clinical inputs to this area, arrangements have been made with Finance and Procurement colleagues as well as General and Service Managers to improve understanding and application.
- Bank/Agency Nursing is procured via Regional Nurse Bank Service which has in place relevant governance processes.

Please provide Information on your methods of monitoring compliance when planning and securing services

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- All new Contracts/SLAs are sent to Commissioning Contracts Manager in the first instance for checking and adding of extract referring to obligations under HCSSA 2019.
- Any suppliers are only awarded contracts following a robust options appraisal, in line with current Procurement guidance.

- As part of our broader efforts to raise awareness, communicate, and provide training to support the implementation of the Act, we are ensuring that staff understand their responsibilities and how the Act applies to all contracts, agreements, and arrangements

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, when procuring from private hospitals, the organisation has incorporated the requirements of the Act into the tender process.	This should describe how the success, achievement or learning could be used in the future. For example, the learning from tendering with private hospitals is now being used to implement arrangements in other types of procurement.
• All NHSB Commissioned Services from NHS, Private or 3rd Sector providers.	• written SLAs with the English trusts have an extract that refers to requirements under HCSSA. • Any new Private Provider placements this year have the extract added on as an Appendix to the agreement. • Discussions held with relevant stakeholders in Planning & Procurement, Finance to raise awareness of the relevant Duties of HCSSA legislation • Generic clause for Board-to-Board SLA Agreements developed in collaboration with CLO.	• As NHS Bodies are regulated and inspected, learning can be taken from commissioning requirements with other NHS Boards and applied to any commissioning agreements with other sectors. • Planning and procurement teams have increased awareness of the legislation and active engagement in implementation of this Duty to continue.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may have been difficulties in planning or securing services in a speciality area	This should describe what actions have been / are being / will be taken to address the situation. For example, engaging with service providers to ensure that they understand what information and

	due to a lack of assurance around the appropriateness of staffing arrangements.	assurance is required, seeking alternative service providers etc.
Some contracts may be generated nationally.	• Local Boards may not have full oversight of Commissioning process utilised.	• Liaison with national colleagues around commissioning of services to ensure that Board requirements are duly met.
Independent contractor services – Optometry, Dental and GP	• Lack of statutory authority to require staffing information from independent contractors, particularly in optometry, dental and general practice services.	• Be cognisant of updated national guidance when available from Scottish Government which will strengthen compliance.
Lack of consistency across NHS Scotland.	• More guidance required from Scottish Government which will be released in the next year.	• Once further guidance is available, review wording of contracts and SLAs further to ensure compliance.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Staff Governance Committee Minutes**
Responsible Executive/Non-Executive:	**D Parker, Chair Staff Governance Committee**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Staff Governance Committee 16 December 2025
- Staff Governance Committee 30 January 2026

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Staff Governance Committee minutes 17.07.25
- Appendix No 2, Staff Governance Committee minutes 16.12.25

Staff Governance Committee

A meeting of the **Staff Governance Committee** will be held on **Thursday 17 July 2025** at 11am via MS Teams

Present:
D Parker (Chair)
K Hamilton, Chair of NHS Borders Board

In Attendance:
P Moore, Chief Executive
A Carter, Director of HR, OD & OH&S
E Cameron, Head of OD
C McGee, PA to the Director of HR, OD & OH&S
A Paterson, Deputy Director of HR
J Boyle, HR Manager, BGH, Catering, Estates, Finance & General Services
R Brydon, Interim Head of Health & Safety
S Bhatti, Director of Public Health
J McLaren, Employee Director
C Smith, Head of Workforce
G Russell, Partnership Lead, Mental Health
V Mann, Partnership Lead, Staffside
M O'Reilly, Chief Nurse Clinical and Professional Development
C Wilson, General manager, Primary Care & Community Services

1. ANNOUNCEMENTS & APOLOGIES

1.1 Apologies had been received from L Livesey, Non-Executive, K McLauchlan, Head of OHS.

1.2 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 **STAFF GOVERNANCE COMMITTEE** noted there were no verbal declarations.

3. MINUTES OF PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Staff Governance Committee held on 17 April 2025 were approved.

4. MATTERS ARISING

4.1 **Action 8 update:** The Once for Scotland policies remained on hold for the time being, with the expectation that they would go live within the next few weeks. J

Boyle will bring a detailed presentation to the October meeting, providing an overview of the new policies and highlighting any changes from the current versions

The **STAFF GOVERNANCE COMMITTEE** noted the Action Tracker.

5. IMATTER UPDATE

5.1 E Cameron provided an overview of the iMatter report.

5.2 Key points included a 6% increase in visibility of board members and a stable Employee Engagement Index (EEI) of 77%. An IT issue affecting confidentiality was reported and was under investigation. Action planning was ongoing and a fuller report would be presented at the next meeting.

The **STAFF GOVERNANCE COMMITTEE** noted the update.

The **STAFF GOVERNANCE COMMITTEE** confirmed the level of assurance it had received from the report was Moderate Assurance.

6. PEOPLE METRICS: DISCUSSION

6.1 C Smith provided an overview of the provision of workforce metrics.

6.2 The dashboard included metrics such as sickness absence, vacancies, appraisals and employee relations cases. Suggestions were made to include trend data and e-learning metrics and the publication of the infographic via a staff share.

The **STAFF GOVERNANCE COMMITTEE** noted the report.

The **STAFF GOVERNANCE COMMITTEE** supported the publication of the infographic via a staff share.

The **STAFF GOVERNANCE COMMITTEE** confirmed the level of assurance it had received from the report was Significant Assurance.

7. DRAFT ANTI-RACISM PLAN

7.1 A Carter provided an overview of the provision of the Draft Anti-Racism Plan.

7.2 The plan was 70% complete and included actions such as establishing an Anti-Racism Committee and collecting KPIs from ethnic minority staff. Feedback was provided on ensuring equity across all protected characteristics and improving engagement. The plan would be finalised after further consultation.

The **STAFF GOVERNANCE COMMITTEE** noted the report.

The **STAFF GOVERNANCE COMMITTEE** confirmed the level of assurance it had received from the report was Moderate Assurance.

8. PERFORMANCE OF PRIMARY AND COMMUNITY SERVICES UNDER THE STAFF GOVERNANCE STANDARD

8.1 C Wilson provided an overview of what Primary and Community Services were doing to satisfy obligations under the Staff Governance Standard.

8.2 Highlights included a staff charter, newsletters, training dashboards, and a new health and safety framework. The Committee commended the work and suggested sharing it across the organisation.

The **STAFF GOVERNANCE COMMITTEE** noted the presentation.

The **STAFF GOVERNANCE COMMITTEE** confirmed the level of assurance it had received from the report was Significant Assurance.

9. OCCUPATIONAL HEALTH & SAFETY FORUM MINUTES: 20.01.25; 03.03.25

The **STAFF GOVERNANCE COMMITTEE** noted the minutes.

10. TRAINING EDUCATION & DEVELOPMENT BOARD MINUTES: 04.06.25

The **STAFF GOVERNANCE COMMITTEE** noted the minutes.

11. WHISTLEBLOWING GOVERNANCE GROUP MINUTES: 08.11.24; 31.01.25

The **STAFF GOVERNANCE COMMITTEE** noted the minutes.

12. STAFF GOVERNANCE STANDARD – REFRESHER

12.1 E Cameron shared a presentation on the Staff Governance Standard.

12.2 Discussions included the need to re-establish the Staff Governance Working Group, improve awareness of staff governance, and align with the organisational values.

The **STAFF GOVERNANCE COMMITTEE** noted the presentation and that a Development session would be scheduled later in the year.

13. ANY OTHER BUSINESS

13.1 P Moore highlighted the importance of the work done on the Strategy and emphasised the importance of the social compact, values and behaviours at work. J McLaren emphasised adherence to national policies. The committee agreed to align ambition with legal frameworks.

14. DATE AND TIME OF NEXT MEETING

14.1 The Chair confirmed the date of the next scheduled meeting of the Staff Governance Committee would take place on Thursday, 16 October 2025 at 11am via MS Teams.

Staff Governance Committee
Minutes

A meeting of the **Staff Governance Committee** was held on **Tuesday 16th December 2025** at 11am via MS Teams

Present: D Parker (Chair)
L Livesey (Non-Executive Member)
J McLaren (Employee Director – Joined after Item 1)

In Attendance:
E Cameron (Head of OD)
A Paterson (Deputy Director of HR)
C Smith (Head of Workforce)
R Brydon (Interim Head of Health & Safety)
I Bishop (Committee Administration/Recording)

1. ANNOUNCEMENTS & APOLOGIES

1.1 No apologies had been received

1.2 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 **STAFF GOVERNANCE COMMITTEE** noted there were no verbal declarations.

3. MINUTES OF PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Staff Governance Committee held on 17 July 2025 were approved.

4. MATTERS ARISING

4.1 **Strategic Risk Development**
This action was confirmed as completed. The tracker will be updated from Amber to Closed.

Development Session (Staff Governance Standard)
Due to limited responses, the Committee agreed to keep the action open and schedule a development/training session for Non-Executive Members in late January or early February 2026.

Whistleblowing – Confidential Contacts
Meetings had previously been arranged and then cancelled around ten months ago and had not been reinstated. There is currently no clarity on the Executive Lead.
Action: Head of OD to confirm the Executive Lead and reinstate the meeting programme.

Policy Updates
The update paper was not provided due to presenter availability.
Action: Deputy Director of HR to schedule the policy update for January 2026.

Action Concerns
Some actions older than 12 months were still marked Amber, which did not reflect the true delay.
Action: Committee administration to update RAG definitions to reflect correct timescales.

Outcome
The Committee approved the Action Tracker subject to the above updates.

The **STAFF GOVERNANCE COMMITTEE** noted the Action Tracker.

5. STAFF GOVERANCE WORKPLAN 2026/2027

5.1 The **Head of OD** presented the draft **2026/27 Work Plan** structure:

- **Routine standing items** and **statutory/other minutes**.
- **Annual service-level reports** from **Acute**, **Mental Health**, **Corporate Services**, and **Primary & Community Services**.
- Alignment to the **five elements of the Staff Governance Standard**.

Additional components:

- **Regular assurance** on the **Health and Care Staffing (Scotland) Act**.
- A **Committee development session** on the Staff Governance Standard (roles, expectations, cross-committee interfaces).

Members **welcomed** the clarity, alignment to the wider **assurance framework**, and emphasis on **thematic review**.

Outcomes / Actions

1. **People & Wellbeing Strategy delivery plan** to be scheduled for **January 2026 SGC** for **discussion and sign-off**.
2. **Whistleblowing** to become a **standing quarterly item** on the SGC agenda (in addition to Board-level public reporting).
3. **Anti-Racism Plan** to be **added to January 2026 SGC** ahead of consideration at **February 2026 Board**.

The Committee confirmed **SIGNIFICANT ASSURANCE** for this item.

5.2 The Committee confirmed **SIGNIFICANT ASSURANCE** for this item.

6. STAFF GOVERANCE MONITORING – ANNUAL REPORT 2024/2025

6.1 The Head of OD confirmed that the Staff Governance Monitoring return for 2024/25 had been cleared under Chair's action and submitted to the Scottish Government on time, with minor amendments reflecting Executive Leads and the developing People & Wellbeing Strategy. The Committee noted concerns that the national reporting cycle is no longer aligned with the local Annual Review timetable, reducing its usefulness. The Head of OD will raise timing and format issues with Government colleagues. The Committee agreed the monitoring discussion should continue to support identification of key organisational themes and escalation of any risks to the Board. **The report was noted and proposed actions endorsed.**

6.2 The Committee **noted the report**. The Committee **endorsed the proposed actions**. **No assurance level** (e.g., Significant / Moderate / Limited) was stated or implied. The item did **not** ask the Committee to provide assurance — it was presented **for awareness / noting**, not for assurance.

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7. EMPOYEE RELATIONS ACTIVIY 2024/2025

7.1 The Deputy Director of HR presented the annual Employee Relations overview, covering bullying and harassment, capability, conduct, grievance cases and policy investigations. Trends for 2024/25 showed *stable bullying and harassment levels* and *reductions in capability and conduct cases*, although members noted the complexity of interpreting the figures due to collective cases and their impact on protected characteristic reporting. BGH recorded the highest number of grievances, reinforcing the need for continued focus on early resolution and local engagement. Workforce investigations increased from 20 to 26, reflecting greater case complexity and emphasising the importance of earlier management intervention. The Committee also noted a further rise in ER activity in the six months following the reporting period and agreed that HR and Staff-Side should work jointly to improve the industrial relations climate, encouraging informal resolution and strengthening managerial confidence. Future reports will include case demographics alongside workforce baselines to better highlight disproportionate patterns. The Deputy Director confirmed that the new Power BI dashboards under development will support monthly, real-time oversight.

7.2 The Committee confirmed **MODERATE ASSURANCE** for this item.

8. MENTAL HEALTH STAFF GOVERNANCE REPORT

8.1 The Committee reviewed the Mental Health Staff Governance paper in the absence of the service presenters. The report provided an open overview of performance,

highlighting statutory training compliance at approximately **86.2%**, role-mandatory training at **61%**, and annual appraisal completion at **58.6%**. Governance structures were outlined, including formal operational meetings, Clinical Care & Governance Group oversight and service reviews. The paper also described actions underway to address low-compliance areas through refresher learning, provision of protected time, and focused managerial support, particularly in high-acuity areas. Partnership working, MDT arrangements and cultural initiatives—such as Safe Wards implementation and development of a single point of access—were also referenced. Members welcomed the transparency of the report but remained concerned about the pace of improvement in mandatory/statutory training and appraisal completion.

8.2 Mental Health leadership to attend the **January 2026 SGC** meeting to present the improvement plan, required resourcing, milestones, and proposed assurance measures.

8.3 The Committee confirmed **LIMITED ASSURANCE** for this item.

The **STAFF GOVERNANCE COMMITTEE** noted the presentation.

9. PEOPLE DASHBOARDS (MONTHLY & TRENDS)

9.2 The Head of Workforce presented the updated Monthly People Dashboard and the new Trends Dashboard, now hosted on NSS with appropriate access controls. The Monthly Dashboard now incorporates an overall absence rate and divisional hotspots, with Anxiety/Stress/Depression displayed explicitly to support targeted interventions. The Trends Dashboard provides two-year SPC analyses for absence (and underlying causes), headcount/FTE, vacancies, appraisals and ER indicators, with drill-down capability by division and job family.

- The Committee welcomed the improved accessibility and functionality of both dashboards and requested further enhancements, namely:
- reinstatement of the 4% absence target line to align with organisational aims and budget assumptions;
- inclusion of cross-division comparative views (e.g., appraisals) to highlight good practice and encourage spread; and
- addition of mandatory/statutory training compliance to complete the assurance profile.
- Due to continued low appraisal completion rates, the Committee agreed this represents an organisational risk and should be escalated to the Board through the People & Wellbeing Strategy delivery plan.

9.3 ACTION - A desktop analysis of part-time staff with multiple contracts to inform the Fair Living Hours initiative, undertaken by the Head of Workforce with input from the Employee Director.

9.4 The Committee confirmed **LIMITED ASSURANCE** for dashboard presentation and content. **LIMITED ASSURANCE** for the underlying workforce performance highlighted by the data.

10. OCCUPATIONAL HEALTH & SAFETY FORUM - TERMS OF REFERENCE

10.2 The Interim Head of Health & Safety presented the revised Terms of Reference for the OH&S Forum. The updates clarified the Forum's remit, strengthened the escalation process (including actions for overdue items, repeated non-attendance and conduct standards), and increased leadership accountability by requiring Director-level attendance at least once per year. The revised ToR also reinforced the Forum's role in monitoring OH&S risks, supporting Staff Governance Standard 5 (safe working environment) and receiving reports on adverse events, risk assessments and training compliance.

10.3 The **STAFF GOVERNANCE COMMITTEE approved** the revised terms of reference.

10.4 The Committee confirmed **SIGNIFICANT ASSURANCE** for this item.

11. WHISTLEBLOWING GOVERNANCE GROUP MINUTES:

11.2 The Committee noted the minutes of the Whistleblowing Governance Group and discussed several assurance gaps, particularly around clarity of Executive leadership for whistleblowing and the continuity of administrative support. With an internal audit scheduled for January 2026, members emphasised the need for clearer procedures, timelines, learning mechanisms, and harm review processes to strengthen governance.

11.3 The **Chair** will write to the **Chief Executive** to escalate these concerns and request formal confirmation of the **Executive Lead** and the **future administrative support arrangements**. The Committee also agreed that **whistleblowing updates will be added as a standing SGC agenda item** to support thematic learning and ongoing operational follow-through.

11.4 No formal assurance level was provided for this item. The report was **noted**, and the Committee **identified gaps requiring escalation**, rather than giving an assurance rating.

The **STAFF GOVERNANCE COMMITTEE** noted the minutes.

12. ANY OTHER BUSINESS

12.2 No additional items were raised. The Chair thanked members for their flexibility in taking Item 9 earlier and for constructive challenge around appraisals and whistleblowing, both of which will return in January 2026 for progress tracking and assurance.

13. DATE AND TIME OF NEXT MEETING

13.2 The Committee agreed to reschedule the next meeting from Thursday 29 January 2026 to Friday 30 January 2026 (time to be confirmed). Committee administration will issue an updated invitation.

Minutes – Tammy Chapman Personal Assistant to the Director of People & Culture

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Area Clinical Forum Minutes**
Responsible Executive/Non-Executive:	**P Williams, Non Executive**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Area Clinical Forum with the Board.

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Area Clinical Forum 12 March 2026

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Area Clinical Forum minutes 11.12.25

Area Clinical Forum
11th December 2025
Microsoft Teams

No	Item
1	**Welcome and Apologies** **Chair**: P Williams **Present**: P Williams (Chair), R Duncan, M Cunningham, R Devine, M Clubb, F Sandford, N Hall, P Grieve, C Proudfoot, A Harrison, G Laker, B Thomson (Admin) **Apologies**: A Downie, I Hayward, K Harvey, M O'dwyer ***Please note that co-pilot was used to transcribe these minutes as a trial to improve meeting efficiency.***
2	**Terms of Reference Discussion** • It was raised that public health was not represented in the current membership. Paul and Malcolm discussed the need to broaden membership beyond just chairs and vice chairs of professional subcommittees, considering inclusion of clinical leaders such as associate nurse directors and directors of pharmacy, as ex officio members without voting rights ***FOR ACTION:*** P Williams & M Clubb to review the forum's terms of reference against statutory regulations to ensure compliance, while also considering how to include broader clinical perspectives without breaching regulatory requirements. ***FOR ACTION:*** C Proudfoot to seek interest from PNMLC to attend Area Clinical Forum (ACF) and invite P Williams to a meeting next year. • It was emphasised the importance of ensuring the primary care perspective is strongly represented in both the forum and at board level, agreeing that independent partners in optometry and dental should also have their voices heard.
3	**Deputy Chair Discussion** • C Proudfoot and P Williams to have a conversation out with the call regarding this. ***FOR ACTION:*** P Williams/B Thomson to circulate a call for nominations for the Vice Chair position and arrange a vote if more than one nomination is received.

4	**NHS Board Feedback & Clinical Strategy and Enabling Strategies** • It was reported that the board was highly supportive of the new clinical strategy, and it was stressed the importance of staff feeling consulted and able to own the strategy. It was confirmed that extensive engagement workshops were held when developing the strategy, and the document reflects broad clinical input. • The complexity of implementing the strategy across multiple specialties was discussed, noting the risk of reverting to siloed approaches. It was highlighted there is a need for integration and clear communication between community and hospital services, especially regarding shared care and funding arrangements • Members advocated for the development of a primary care strategy aligned with the clinical strategy's person-centred approach, encouraging primary care professionals to take ownership and contribute to its creation. • The Chair proposed that the ACF should play a leading role in sense-checking and advising on significant clinical service changes, ensuring that clinical perspectives are considered before decisions are made at the Borders Delivery Group or board level. ***FOR ACTION:*** All members to take the newly launched clinical and organisational strategies to their respective professional forums for discussion and feedback, focusing on consultation and ownership.
5	**Professional Forum Escalations/Celebrations** • R Duncan highlighted the uncertainty around continued funding for the primary care improvement fund, noting the risk to staff contracts and the potential impact on allied health professionals, nursing, and pharmacy teams, with provisional board support extending only until September. • N Hall reported ongoing efforts to relieve hospital waiting lists, particularly for cataract and glaucoma, and described challenges in referral processes and interdepartmental communication, emphasising the need for streamlined pathways and better integration between community and hospital services. • P Grieve described increasing pressures from flu, RSV, and D&V, leading to challenges in isolation and bed management, but also noted the upcoming launch of the frailty unit, integrated discharge team, and expansion of hospital at home services as positive steps. • A Harrison shared the success of a recent event showcasing AHP services within children and young people's services, highlighting the benefits of multidisciplinary collaboration and pathway integration, with Paul noting positive examples of linking early years screening with community opticians.
6	**Borders Delivery Group** • The Chair described the creation of the Borders Delivery Group to broaden decision-making and recounted a recent pharmacy service review that would have benefited from prior discussion at the ACF, allowing for clinical endorsement or risk escalation.

	• P Grieve & R Devine supported the idea of routing significant service reviews and workforce issues through the ACF for clinical discussion, noting that rushed decisions at the delivery group level can overlook important clinical risks and perspectives. • F Sanford and P Grieve debated whether certain workforce papers should go to staff governance or the ACF, agreeing that issues with significant clinical impact should be considered by both, and the Chair committed to clarifying governance pathways with the relevant chairs. ***FOR ACTION:*** Paul to speak to Chief Exec. regarding the process for significant clinical service changes to be reviewed by the ACF before going to the Borders Delivery Group.
7	**AOCB** • *Nothing to note.*
	Date and Time of Next Meeting: Thursday 12th February 2026, 1230-1330 via MST.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Whistleblowing Quarter 4 Report**
Responsible Executive/Non-Executive:	**A Keen, Director of People & Culture**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

To provide the Board with the Quarter 4 report on Whistleblowing.

2.2 Background

The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in those services, whether they are directly employed by the NHS or a contracted organisation. The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow.

Health Boards have particular responsibilities regarding the implementation of the Standards:

- Ensuring that their own whistleblowing procedures and governance arrangements are fully compliant with the Standards.
- Ensuring there are systems in place for primary care providers in their area to report performance data on handling concerns.
- Working with higher education institutions and voluntary organisations to ensure that anyone working to deliver NHS Scotland services (including students, trainees and volunteers) has access to the Standards and knows how to use them to raise concerns.

2.3 Assessment

The Standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements:

- Learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns.
- The experience of all those involved in the whistleblowing procedure.
- Staff perceptions, awareness, and training.

2.3.1 Quality/ Patient Care

Patient Safety/Clinical Impact implications will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

2.3.2 Workforce

Staffing implications will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

2.3.3 Financial

Resource implications will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

2.3.4 Risk Assessment/Management

Risk assessment will be addressed in the management of any findings/actions/decisions resulting from any whistleblowing concerns raised.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Climate Change

Not Applicable.

2.3.7 Other impacts

Not Applicable.

2.3.8 Communication, involvement, engagement and consultation

Not Applicable.

2.3.9 Route to the Meeting

This has been formulated directly for the Board.

2.4 Recommendation

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

The Board is asked to note the Whistleblowing Quarter 4 report.

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

- Significant Assurance
- **Moderate Assurance (recommended)**
- Limited Assurance
- No Assurance

If a single level of assurance cannot be determined Officers are asked to suggest a level based on the following split of assurance:

- **Systems and Processes**
- **Outcomes**

3 List of appendices

The following appendices are included with this report:

- Appendix No1: Whistleblowing Quarter 4 Report

Whistleblowing Performance Report

Quarter 4

1 January 2026 to 31 March 2026

Author: Iris Bishop, Board Secretary/INWO Liaison Officer

Contents Whistleblowing Concerns – Quarter 4

1. CONTEXT

The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in those services, whether they are directly employed by the NHS or a contracted organisation. The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow.

Health Boards have particular responsibilities regarding the implementation of the Standards:

- Ensuring that their own whistleblowing procedures and governance arrangements are fully compliant with the Standards.
- Ensuring there are systems in place for primary care providers in their area to report performance data on handling concerns.
- Working with higher education institutions and voluntary organisations to ensure that anyone working to deliver NHS Scotland services (including students, trainees and volunteers) has access to the Standards and knows how to use them to raise concerns.

To comply with the whistleblowing principles for the NHS as defined by the Standards, an effective procedure for raising whistleblowing concerns needs to be:

> *'open, focused on improvement, objective, impartial and fair, accessible, supportive to people who raise a concern and all people involved in the procedure, simple and timely, thorough, proportionate and consistent.'*

A staged process has been developed by the INWO. There are two stages of the process which are for NHS Borders to deliver, and the INWO can act as a final, independent review stage, if required.

> • **Stage 1: Early resolution** – for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action – 5 working days.
>
> • **Stage 2: Investigation** – for concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response – 20 working days.

The Standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements:

- Learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns.
- The experience of all those involved in the whistleblowing procedure.
- Staff perceptions, awareness, and training.

2. AREAS COVERED BY THE REPORT

Since the go-live of the Standards in April 2021, processes have been put in place to gather whistleblowing information raised across all NHS services to which the Standards apply. Within NHS Borders in the Health and Social Care Partnership (HSCP) any concerns raised about the delivery of a health service by the HSCP are reported and recorded using the same reporting mechanism which is in place for those staff employed by NHS Borders.

The General Manager for Primary & Community Services has responsibility for concerns raised within and about primary care service provision.

3. IMPLEMENTATION AND RAISING AWARENESS

Work had taken place to raise awareness of the Standards and during this reporting year as part of our improvement plan we are looking to revisit the local processes in place and revise/refresh in light of any learning.

In addition, our plans include the actions outlined below:

- Continue to promote the Standards and how to raise concerns safely within the organisation across the year and specifically utilising Speak Up Week.
- In conjunction with our HR Department train more staff in the process of investigations for both whistleblowing investigations and other investigations.
- Continuous improvement of our processes based on learning and experience.
- Formulate meaningful training plans through our confidential contacts network.
- For each complaint that is upheld or partially upheld formulate an action plan to be put in place to address any shortcomings or apply any identified learning.

4. QUARTER 4 PERFORMANCE INFORMATION JANUARY 2026 – MARCH 2026

Under the terms of the Standards, the quarterly performance report must contain information on the following indicators:

Indicator 1 - Total number of concerns, and concerns by Stage

For the Quarter 4 period we have received 0 concerns at Stage 1 and 0 concerns at Stage 2.

Indicator 2 - Concerns closed at Stage 1 and Stage 2 as a percentage of all concerns closed

For the Quarter 4 period we have 0 concerns closed at Stage 1 and 0 concerns closed at Stage 2.

Indicator 3 - Concerns upheld, partially upheld and not upheld as a percentage of all concerns closed in full at each stage

For the Quarter 4 period there were 0 concerns upheld, partially upheld or not upheld.

Indicator 4 - The average time in working days for a full response

For the Quarter 4 period there have been 0 concerns raised and concluded.

For the Quarter 4 period we have 1 concern at Stage 2. We are encountering challenges in terms of commissioning an external investigator.

This complex case first notification was 13.11.24. The case had been held in abeyance following INWO advice to allow HR processes to conclude, so there have been significant delays. There have been 347 working days since 13.11.24. We are now encountering difficulties in being able to identify a willing external investigator in order to commission the investigation.

Indicator 5 - Number and percentage of concerns closed in full within set timescales

For the Quarter 4 period there have been 0 concerns raised and concluded.

For the Quarter 4 period we have 1 concern at Stage 2. We are encountering challenges in terms of commissioning an external investigator.

5. CONCERNS WHERE AN EXTENSION WAS AUTHORISED

For the Quarter 4 period we have 1 concern at Stage 2.

6. PRIMARY CARE CONTRACTORS

Primary care contractors (GP practices, dental practices, optometry practices and community pharmacies) are also covered by the Standards.

In total 0 returns were received for the Quarter 4 period for Stage 1 or Stage 2 concerns from:-

22 GP Practices
19 Dental Practices
15 Optometry Practices
29 Community Pharmacies

7. ANONYMOUS CONCERNS

Concerns cannot be raised anonymously under the Standards, nor can they be considered by the INWO. However good practice is to follow the whistleblowing principals and investigate the concern in line with the Standards, as far as practicable.

The definition of an anonymous concern is ‘a concern which has been shared with the organisation in such a way that nobody knows who provided the information’.

There were 0 anonymous concerns received during the Quarter 4 period.

8. LEARNING, CHANGES OR IMPROVEMENTS TO SERVICES OR PROCEDURES

System-wide learning, changes or improvements to services can be limited by the need to maintain confidentiality of individual whistleblowers. The future aim is that for each complaint that is upheld or partially upheld a documented action plan will be formulated to address any shortcomings or apply any identified learning.

9. EXPERIENCE OF INDIVIDUALS RAISING CONCERNS

All those who raise concerns are given the opportunity to feedback on their experience of using the Whistleblowing procedure in order that we can learn and make any improvements in our processes as appropriate.

10. STAFF TRAINING

To help staff, NHS Borders has developed a NHSB Raising Whistleblowing Concerns - Guide for Staff (2024), as well as a Whistleblowing Flowchart.

NHS Borders operates an approach where employees act as Confidential Contacts. The purpose of the Confidential Contact is to help people to judge whether their issue is just personal to them (and might constitute a grievance) or of interest to the wider general public. They support people and help them to navigate the recommended whistleblowing approach.

Our previous Director of HR produced a short presentation on "Whistleblowing - What do I need to know and do" and presented to departments across the organisation.

We also signpost our staff to the training available on Turas - National Whistleblowing Standards training on Turas

And also the Training available via INWO:-
In this area you will find additional information and guidance on how to implement the National Whistleblowing Standards and how to handle whistleblowing concerns in your organisation.
Training
Guidance on the National Whistleblowing Standards
Guidance for people receiving concerns
Training materials for Confidential Contacts
Communications materials for NHS use
FAQs
Case study directory
Webinars
Annual reporting

We have updated our procedures and produced an updated SOP/Guidance for Investigators (internal and external) on the back of lessons learnt from a whistleblowing case.

We continue to monitor the uptake of training and promote the TURAS learning modules.

A new Director of People and Culture has been appointed during this reporting period, serving as the Executive Lead for whistleblowing and contributing their expertise to the organisation.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**NHS Borders Integrated Performance Report (IPR) – February 2026**
Responsible Executive/Non-Executive:	**J Smyth, Director of Planning & Performance**
Report Authors:	**H Jacks, P&P Officer** **M 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

An Integrated Performance Report (IPR) has been developed using Power BI, with measures and performance monitoring focussed on a Quality Improvement approach. The IPR reflects our Organisational Strategy commitments, the Annual Delivery Plan (ADP) targets and other local Key Performance Indicators (KPIs). Whilst this version of the IPR does not yet include all measures which we have identified for inclusion, it is an evolving iteration and will be continually developed over the coming months.

2.2 Background

A performance report is presented bimonthly to alternating Board and R&PC meetings so that performance against the key standards (national targets and locally agreed standards) can be scrutinised, and corrective action can be reviewed. **Appendix 2**

outlines the additional measures that will be developed over the coming months and added to the IPR.

The IPR aims to:

- Unify reporting across clinical, operational, and financial domains using a Quality Improvement approach
- Improve transparency and trust through accessible reporting, with one single source
- Enhance decision-making through timely, accurate, and actionable data
- Support continuous improvement by identifying trends and benchmarking performance
- Focus on the measures that require actions to improve

The tables below give an overview of the key symbols displayed in the IPR, clearly illustrating what the data is telling us. Assurances are only for measures that have a target, e.g., Ambulance Handover. This does not include trajectories.

Figure 1: Variation and Assurance Key

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Please note that we cannot provide assurance statuses for all measures without an alternative target line. These may be developed in the future if targets are set.

Figure 2: Astronomical Points – Sigma Violation

Astronomical Points – Sigma Violation

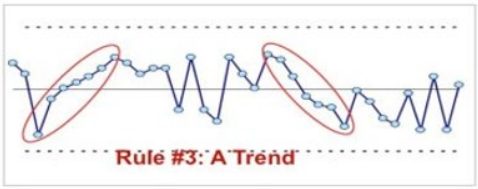
These are points outside the Control Limits, either improving or deteriorating performance depending on colour:

Imp. Ast. Point — Improving Astronomical Point

Det. Ast. Point — Deteriorating Astronomical Point

Shifts

This where there are 6 or more data points in a row above or below the average:

Imp. Shift — Improving Shift Det. Shift — Deteriorating Shift	Eight or more consecutive points above or below the centerline 
Trend This is where there are 6 or more points heading upwards or downwards:	
Imp. Trend — Improving Trend Det. Trend — Deteriorating Trend	Six consecutive points increasing (trend up) or decreasing (trend down) 

2.3 Assessment

The IPR was presented as a first iteration on 11 September 2025 and will continue to be reported on a monthly basis to both the Resource & Performance Committee (R&PC) and NHS Borders Board, for discussion and assurance.

There are no new measures added to this month's report; however, the Business Intelligence team are currently working on incorporating the following data sets into the IPR for the report containing March 2026 data:

- Quality & Safety
- Flu Vaccinations

Lead Directors are accountable for reviewing and formally approving the measures and supporting narrative within their portfolios prior to submission, and they will present this information during the meeting. As there is limited space within the report for narrative, Lead Directors will have the opportunity to elaborate verbally during the meeting if required.

The introduction of the IPR will provide a more cohesive and transparent view of performance across a range of services, over and above those that were referenced specifically in the SG commissioned ADP. Aligned with national policy and local strategic priorities, this approach strengthens governance by enabling Board members to more effectively interpret and connect key performance indicators, identify trends, and assess service impact. It also facilitates more informed scrutiny and challenge, empowering the Board to hold members of the Board Executive Team (BET) to account for operational delivery and continuous improvement.

Moving into 2026/27 and in line with our Organisational Strategy our Performance Framework is being revisited, and a new style report will be brought forward from availability of April 2026 data. This will be refined further once the Board's Delivery Plan for 2026/27 is approved in June 2026 to ensure all required measures are included,

enabling the Board to have a robust reporting system in 2026/27 against agreed key performance measures and Board priorities.

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 Equality & Human Rights Impact Assessment's (EHRIA) as part of delivering 2025/26 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 IPR 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

The Board is asked to note the report:

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

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

- **Systems and Processes** – Moderate Assurance
- **Outcomes** – Limited Assurance

3 List of appendices

The following appendices are included with this report:

- **Appendix 1:** NHS Borders Integrated Performance Report February 2026
- **Appendix 2:** Development of Additional Measures

Integrated Performance Dashboard

February 2026

Last Refresh Date: 24/03/2026

Integrated Performance Dashboard - Information

The Integrated Performance Report contains a page per performance measure where Statistical Process Control charts are used to show whether each measure is under control, or whether there are variations in the data that show performance requires exploring. The charts also show targets for achievement, and this is another consideration when viewing the data (red lines). Is the target being achieved or performance improving towards target or deteriorating. Table 1 below shows the rules that are highlighted in the charts to highlight whether further investigation is required or not.

Confidence Levels – Upper Control Limit (UCL) & Lower Confidence Limit (LCL)

The Confidence Limits are shown in the charts with a dotted line either side of the green mean line. The wider the Upper Confidence Limit and Lower Confidence Limit the more varied the data is, the closer the Limits are together the more stable it is.

Variation			Assurance		
	H L	H L	?	P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Table 1 - Special Cause Variations

Astronomical Points – Sigma Violation

These are points outside the Control Limits, either improving or deteriorating performance depending on colour:

Imp. Ast. Point - Improving Astronomical Point

Det. Ast. Point - Deteriorating Astronomical Point

Shifts

This where there are 6 or more data points in a row above or below the average:

Imp. Shift - Improving Shift

Det. Shift - Deteriorating Shift

Trend

This is where there are 6 or more points heading upwards or downwards:

Imp. Trend - Improving Trend

Det. Trend - Deteriorating Trend

Measure Name	Measure Description	Previous Position	Latest Position	Assurance Status	Variation Status
Emergency Access Standard	Percentage of patients seen within 4 hours of attendance	63.7%	65.3%		
8 Hour Breaches	Percentage of patients who waited greater than 8 hours	18.1%	17.8%		H
12 Hour Breaches	Percentage of patients who waited greater than 12 hours	13.8%	12.9%		H
Length of Stay	Average Length of stay. Non-elective only. Excludes paediatric and obstetirc specialties and ITU wards	10.3	12.2		
Bed Occupancy	Number of acute occupied beds at end of month	90.10%	92.08%		
Delayed Discharges	Number of delayed discharges at end of month	50	52		L
Ambulance Handover Time	Average ambulance handover time in minutes per month	36.92	34.57	F	
AAU Admissions	Number of patients admitted to AAU	410	409		H
Outpatient Waiting List	Number of outpatients waiting over 52 weeks	327	270		L
Inpatient Waiting List	Number of inpatients waiting over 52 weeks	201	142		L

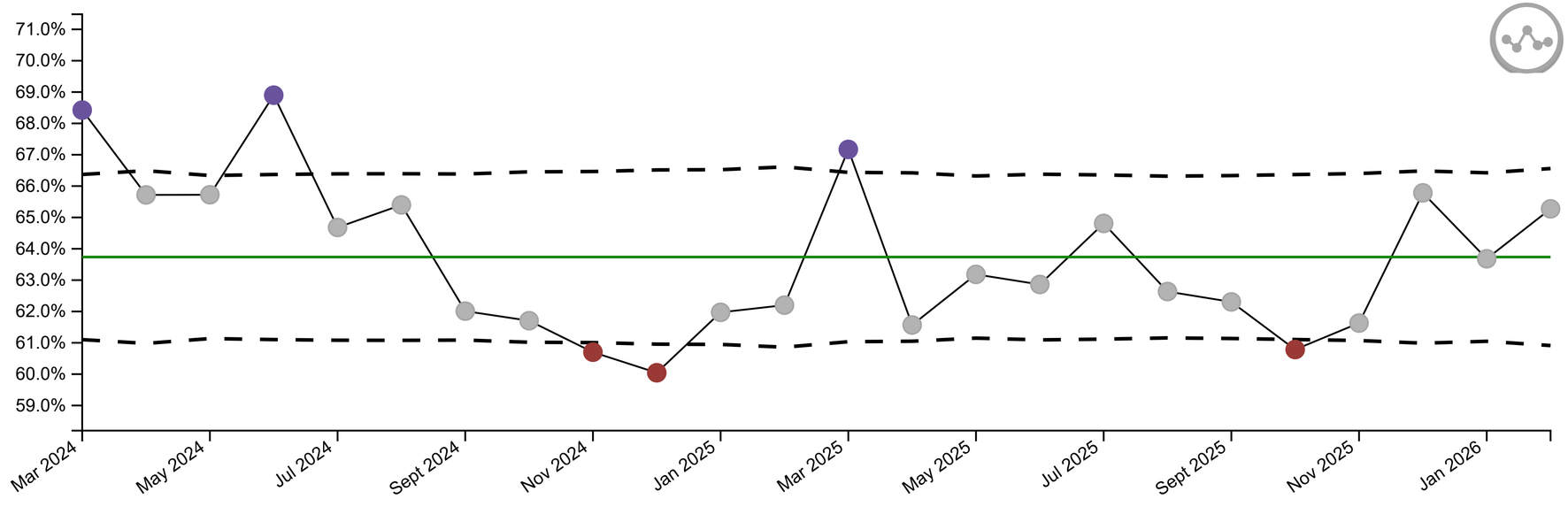
Measure Name	Measure Description	Previous Position	Latest Position	Assurance Status	Variation Status
Theatre Utilisation	Theatre utilisation per month. Elective only, excludes theatre 5	71.3%	71.6%		
Theatres - Cataracts	Average number of cataract cases per session	7.5	6.4		H
Diagnostics Over 6 Weeks	Number of patients waiting over 6 weeks	363	271		L
Cancer 62 Days	Percentage of patients treated within 62 days of referral	76.9%	54.8%	F	
Cancer 31 Days	Percentage of patients treated within 31 days of referral	96.7%	96.3%	?	
Cancer Backlog	Number of patients waiting over 62 days for treatment	38	22		
CAMHS RTT	Percentage of patients received treatment within 18 weeks of referral	100.0%	94.1%	?	H
CAMHS CAT 1	Percentage of Neurodevelopmental Waits seen within 52 weeks	11.11%	12.00%		L
Psychological Therapy	Percentage of patients received treatment within 18 weeks of referral	72.2%	73.3%	?	
BAS 3 Week Target	Percentage of Patients treated within 3 weeks of referral	98.0%	99.0%	P	
Workforce Absence	% of hours lost for all departments per month	6.65%	5.70%	F	L

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

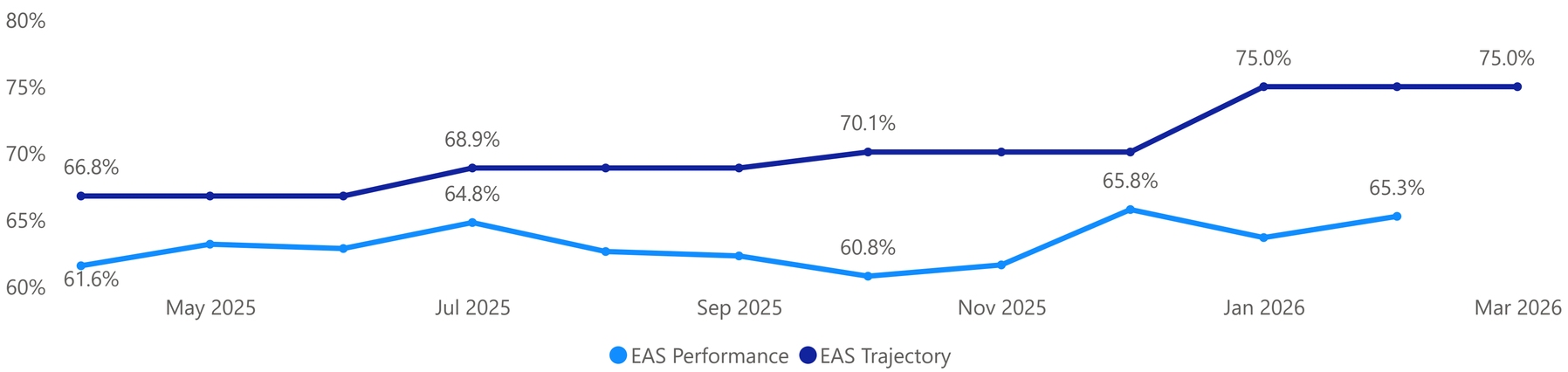
Emergency Access Standard

p-Chart: % of Patients seen within 4 hours of attendance



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Performance against Trajectory



Month

February 2026

The data shows normal variation but is off trajectory. Performance has improved compared to the previous month and within normal variation but remains behind trajectory. Delivery of the unscheduled care improvement programme continues, focusing on leadership & culture, restoration of MAU as an acute assessment model, enhancing AAU and reducing LOS. Embedding of Frailty Assessment Unit and capitalising on additional capacity in H@H & Home First is vital.

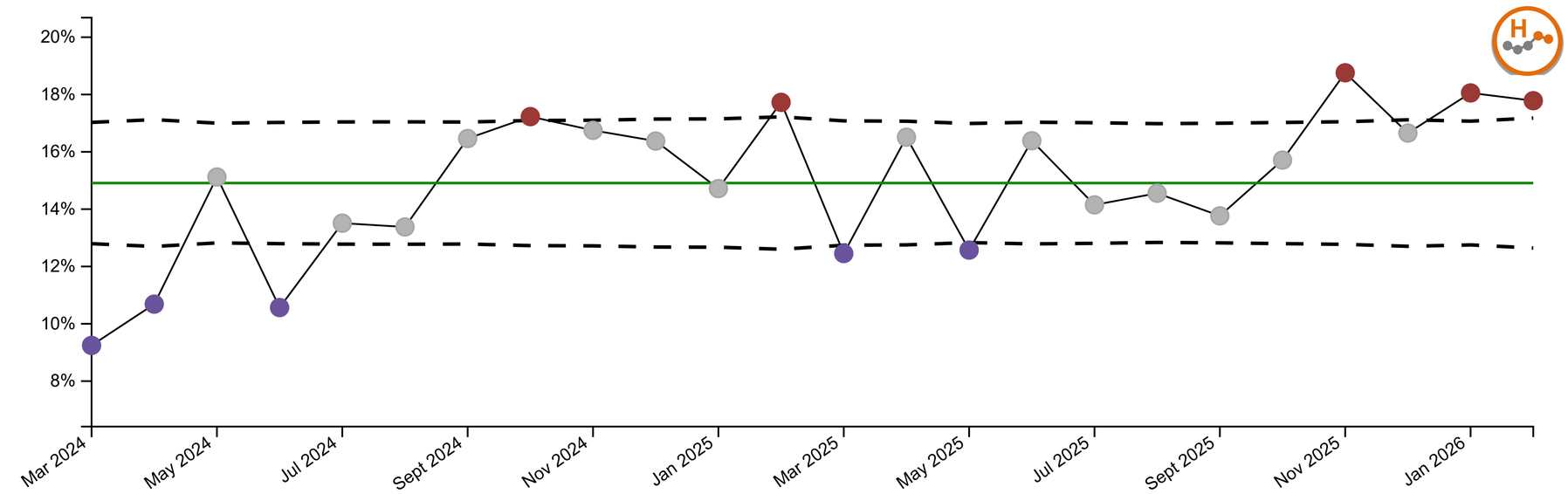
MonthEndDate	Attendances	Breaches	EAS
28/02/2026	2609	1703	65.3%
31/01/2026	2880	1834	63.7%
31/12/2025	2756	1813	65.8%
30/11/2025	2932	1807	61.6%
31/10/2025	3004	1826	60.8%
30/09/2025	3080	1919	62.3%
31/08/2025	3126	1958	62.6%
31/07/2025	3032	1965	64.8%

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

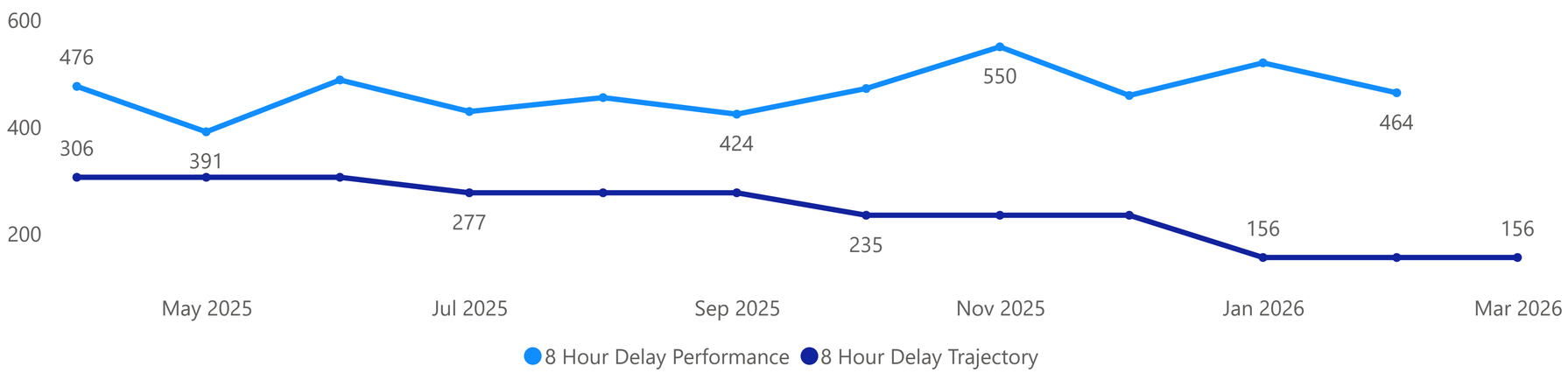
8 Hour Delays

u-Chart: Number of patients who waited more than 8 hours



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Performance against Trajectory



Month

February 2026

The data shows worsening performance (Astro point) and is off trajectory. Performance has deteriorated outside of normal variation and behind trajectory. Continuing to embed what has been delivered and continuing to deliver the unscheduled care improvement plan will reverse the trend in time. Additionally, a new action plan specifically targeting very long-waits has been commissioned to complement existing plans.

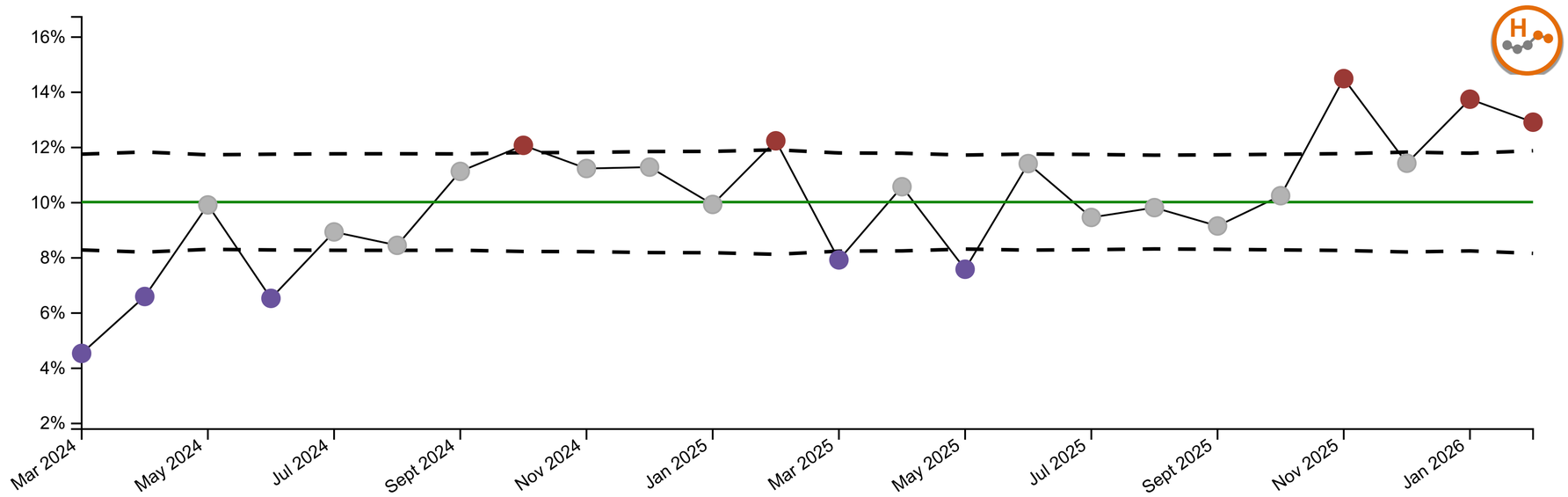
MonthEndDate	Attendances	8 Hour Delays
28/02/2026	2609	464
31/01/2026	2880	520
31/12/2025	2756	459
30/11/2025	2932	550
31/10/2025	3004	472
30/09/2025	3080	424
31/08/2025	3126	455
31/07/2025	3032	429

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

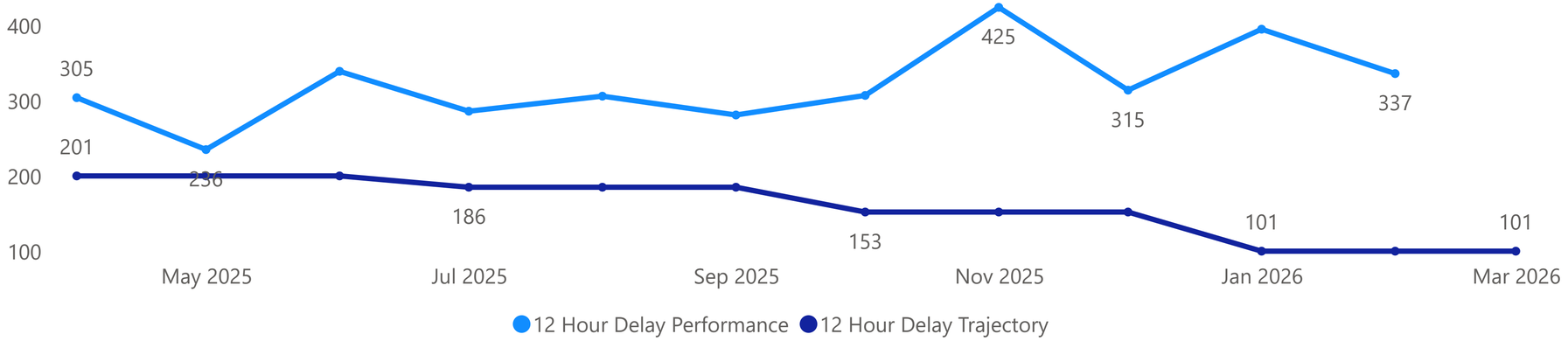
12 Hour Delays

u-Chart: Number of patients waited more than 12 hours



Mean Line — 99% Limits - - - - - - Imp. Trend Det. Trend Imp. Ast. Point Det. Ast. Point Imp. Shift Det. Shift

Performance against Trajectory



Month

February 2026

The data shows worsening performance (Astro point) and is off trajectory. Improved position (1%) against a trajectory of 101, with 337 12 hr breaches in February a reduction from 396 in January. Executive team has commissioned a seperate plan specifically targeting very long waits to compliment the existing improvement plan.

MonthEndDate	Attendances	12 Hour Delays
28/02/2026	2609	337
31/01/2026	2880	396
31/12/2025	2756	315
30/11/2025	2932	425
31/10/2025	3004	308
30/09/2025	3080	282
31/08/2025	3126	307
31/07/2025	3032	287

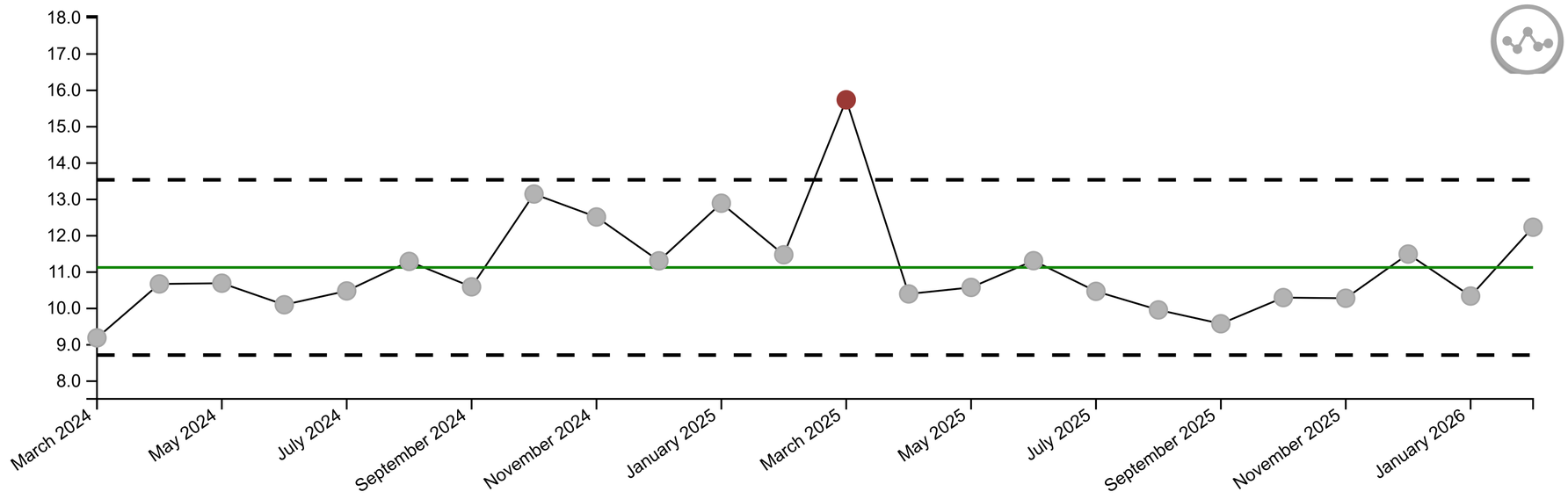
Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

Lead Director: Gareth Clinkscale

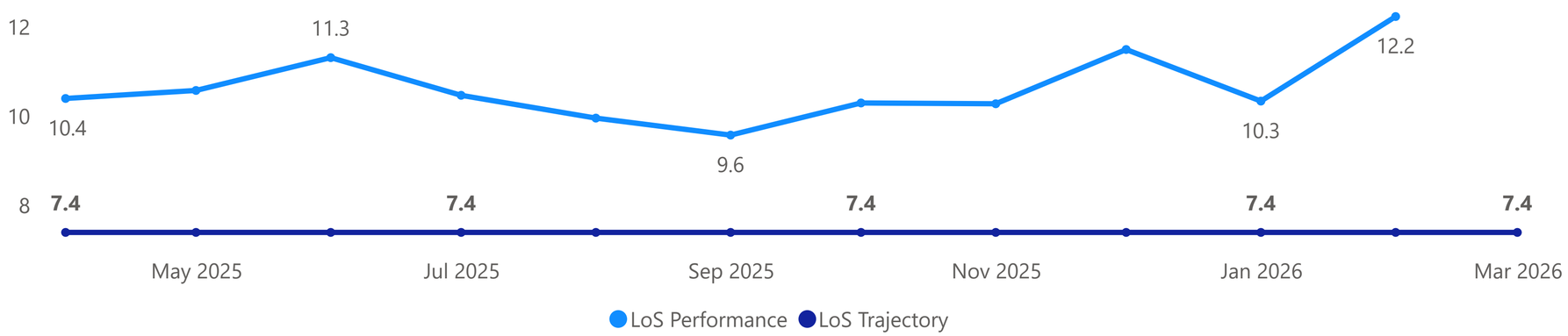
Length of Stay

i-Chart: Average Length of Stay. Non-elective only. Excludes paediatric and obstetric specialties and ITU wards.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Performance against Trajectory



Month

February 2026

The data shows normal variation but is off trajectory. The data shows normal variation at 12.2 days but remains off trajectory. The improvement work through the integrated discharge team and collaboratiove working with home first and hospital at home continues. Frailty indicators are demonstrating improvement however this is yet to translate to significant and sustained reduction in LOS at all age groups.

MonthEndDate	Average Length of Stay
February 2026	12.2
January 2026	10.3
December 2025	11.5
November 2025	10.3
October 2025	10.3
September 2025	9.6
August 2025	10.0
July 2025	10.5

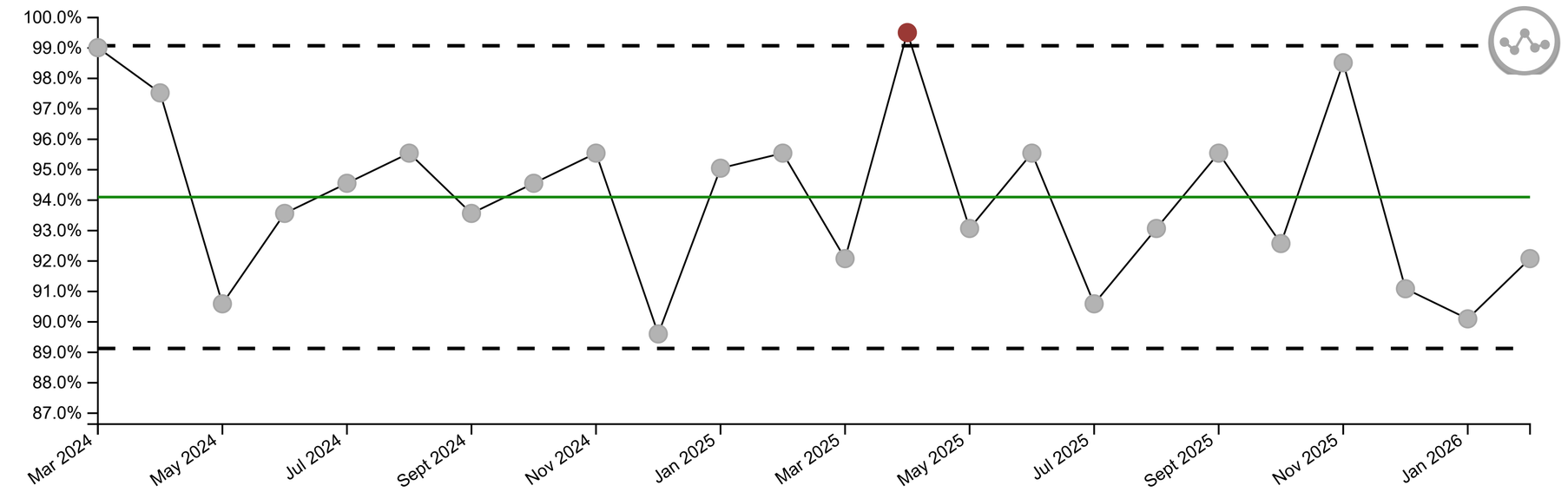
Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

Lead Director: Gareth Clinkscale

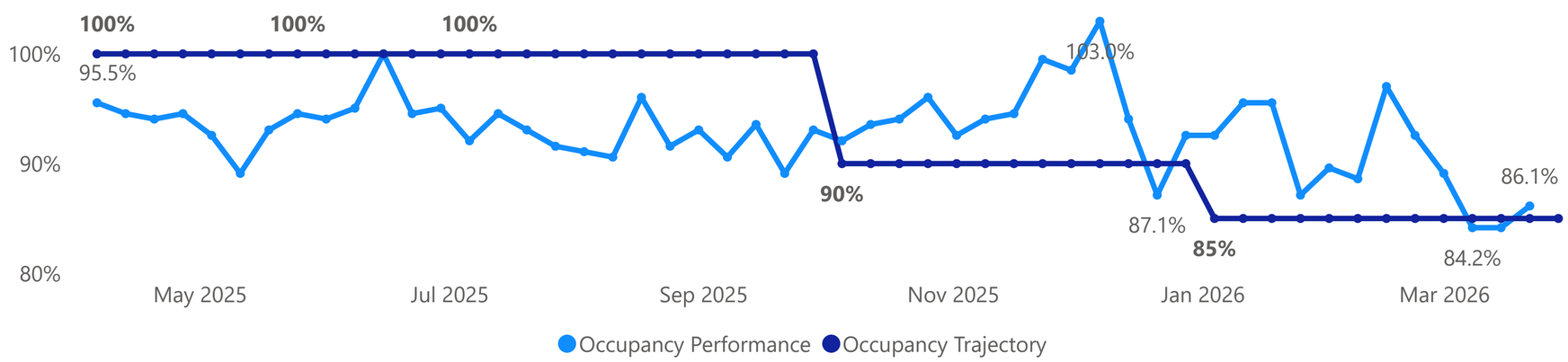
Average Acute Occupancy

p-Chart: Average Number of Acute Occupied Beds



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Performance against Trajectory



Month

February 2026

The data shows normal variation and is on trajectory.

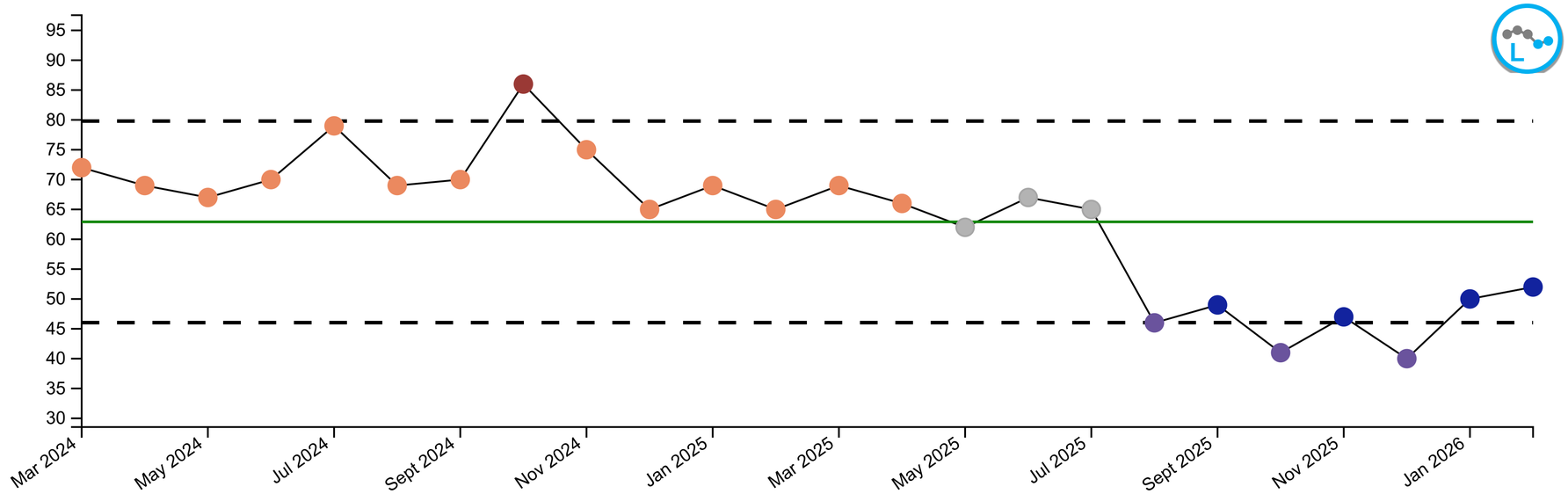
EndOfMonth	Occupied Beds	%
28/02/2026	186	92.1%
31/01/2026	182	90.1%
31/12/2025	184	91.1%
30/11/2025	199	98.5%
31/10/2025	187	92.6%
30/09/2025	193	95.5%
31/08/2025	188	93.1%
31/07/2025	183	90.6%

Integrated Performance Dashboard - Urgent & Unscheduled Care

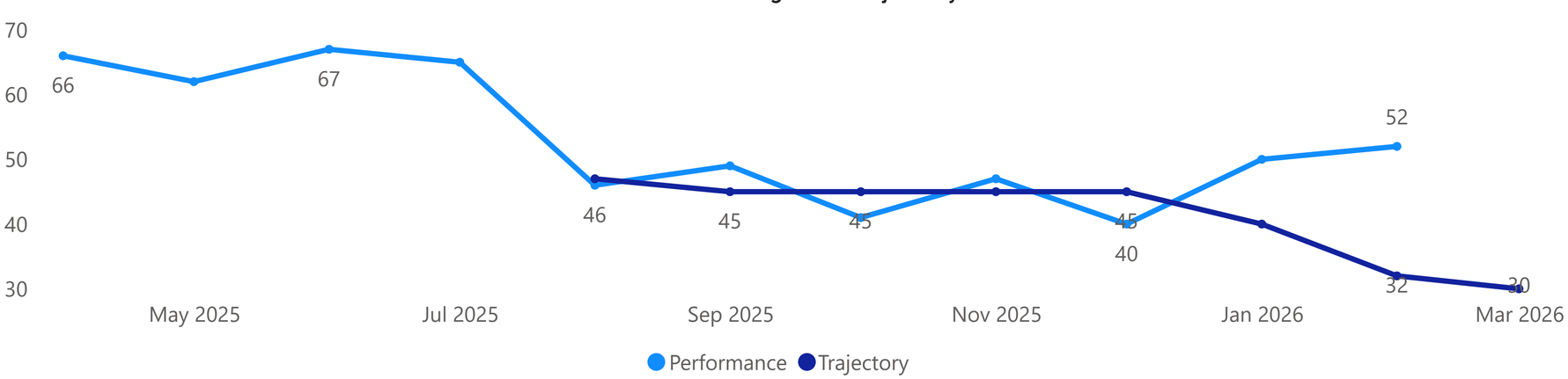
Lead Director: Gareth Clinkscale

Delayed Discharges

i-Chart: Number of Delayed Discharges at end of month



Mean Line — 99% Limits - - - - - - Imp. Trend Det. Trend Imp. Ast. Point Det. Ast. Point Imp. Shift Det. Shift



Month

February 2026

The data shows improving performance (Shift) but is off trajectory. The data demonstrates a slight deterioration from previous month but within normal variation and remains off trajectory at 52 against a trajectory of 32. Main challenges continue to be care at home and enhanced residential care. Planning is underway across the H&SC partnership to develop transformational plans for 2026/27 delivery.

EndOfMonth	Delayed Discharges
28/02/2026	52
31/01/2026	50
31/12/2025	40
30/11/2025	47
31/10/2025	41
30/09/2025	49
31/08/2025	46
31/07/2025	65

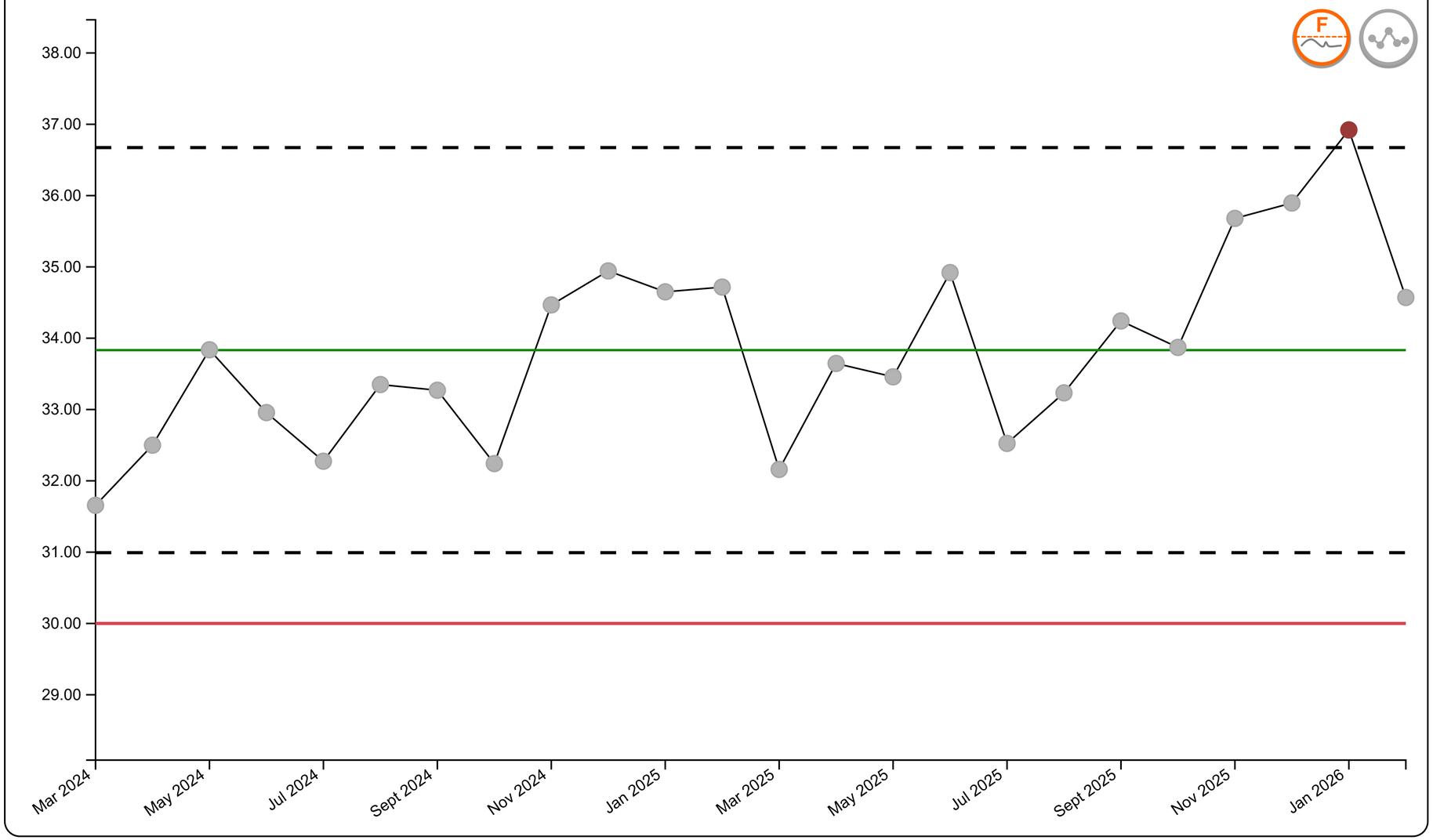
Integrated Performance Dashboard - Urgent & Unscheduled Care

NHS Borders

Lead Director: Gareth Clinkscale

Ambulance Handover Time

i-Chart: Average Ambulance Handover Time in minutes per month



Month

February 2026

The data shows normal variation. Slight improvement on the previous month but within normal variation.

EndOfMonth	Handover Times (Minutes)
28/02/2026	34.57
31/01/2026	36.92
31/12/2025	35.90
30/11/2025	35.68
31/10/2025	33.87
30/09/2025	34.24

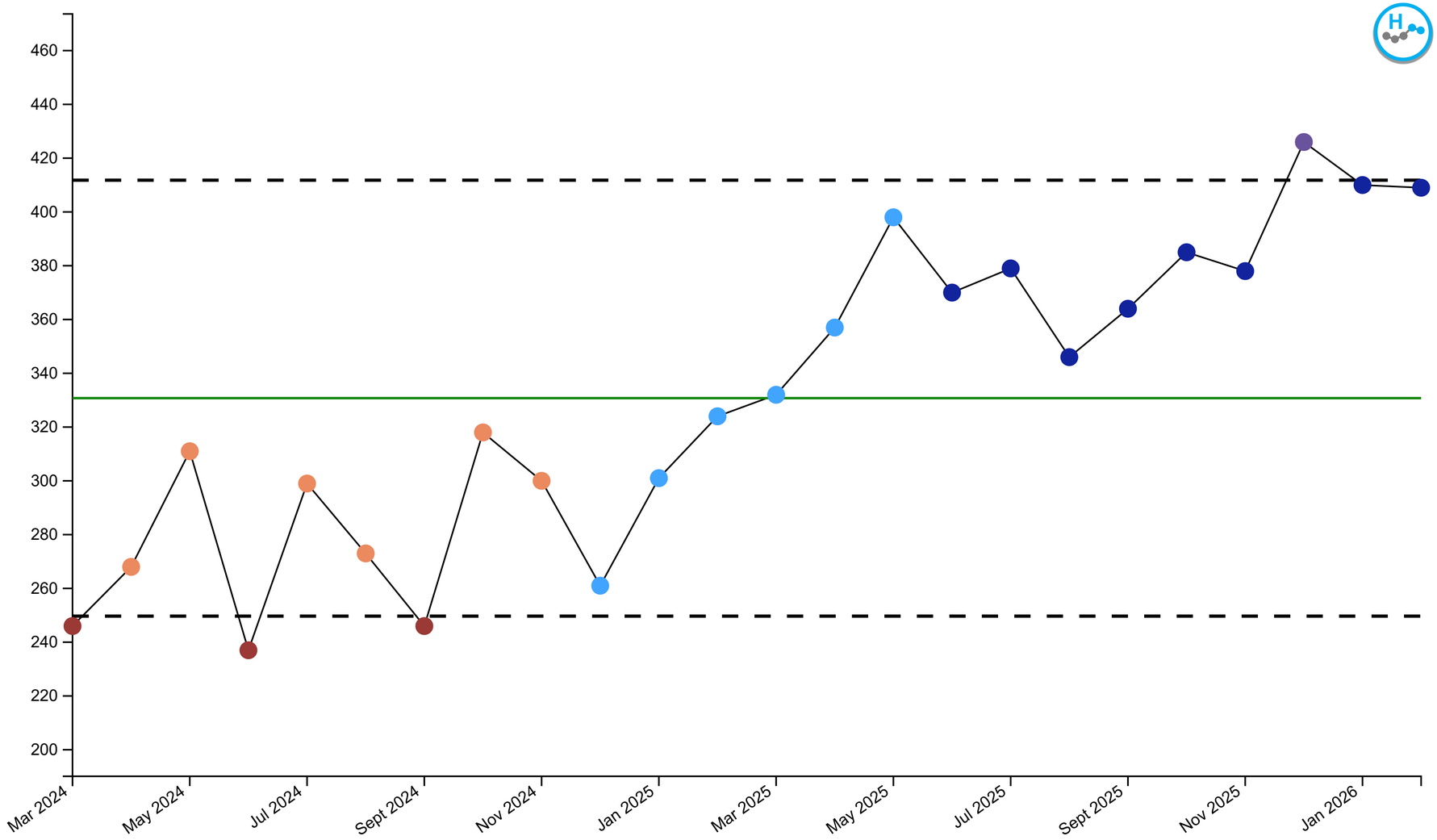
Trajectory — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

AAU Admissions

i-Chart: Number of Patients admitted to AAU



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

February 2026

The data shows improving performance (Shift)
The data demonstrates an overall improving trend.

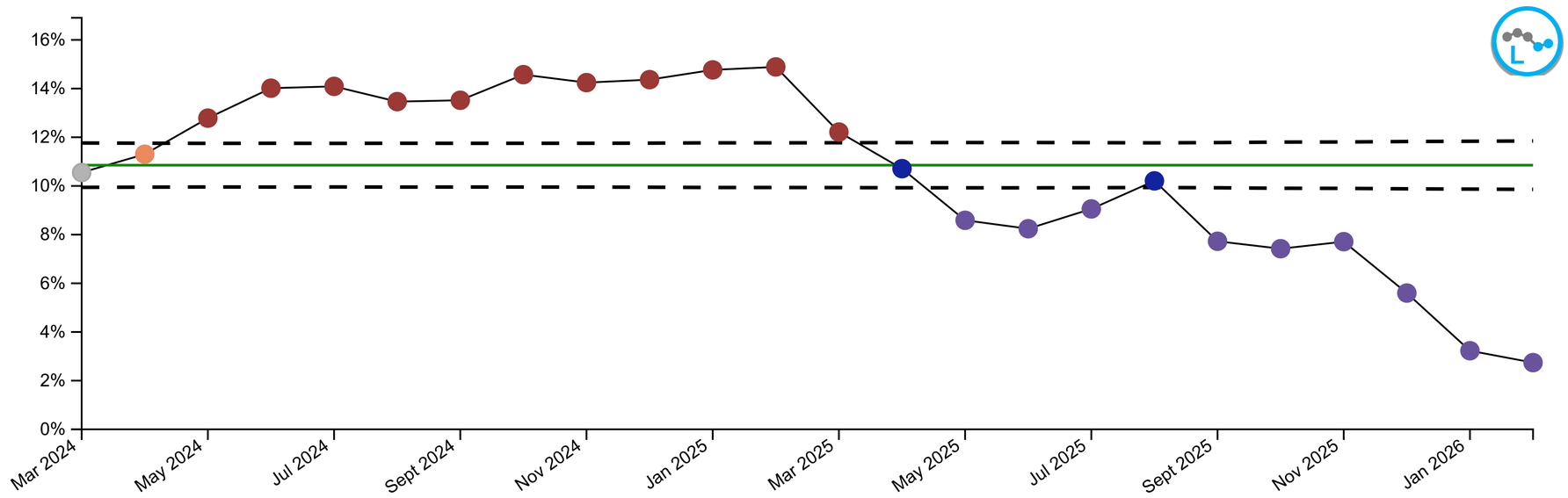
MonthEndDate	Admissions
28/02/2026	409
31/01/2026	410
31/12/2025	426
30/11/2025	378
31/10/2025	385
30/09/2025	364
31/08/2025	346
31/07/2025	379

Integrated Performance Dashboard - Planned Care

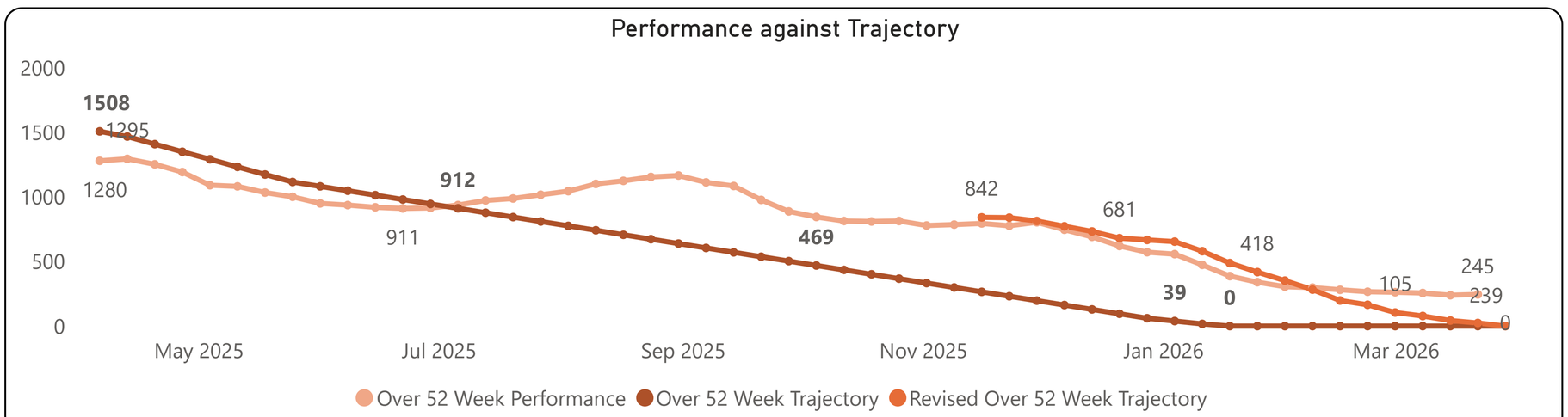
Lead Director: Oliver Bennett

NOP - Over 52 Weeks

u-Chart: Number of Outpatients waiting over 52 weeks



Mean Line — 99% Limits - - - - - - Imp. Trend Det. Trend Imp. Ast. Point Det. Ast. Point Imp. Shift Det. Shift



Month

February 2026

The data shows improving performance (Astro point) but is off trajectory. Data demonstrates continuing significant improvement. With the exception of Dermatology we are still on course meet the required standard of no patient waiting for an appointment for more than 52 weeks. In dermatology due to significant and ongoing workforce challenges we are behind trajectory. Current proposals are for waiting time in dermatology for routine appointments to be managed below 52 week in Quarter 1 of 2026/27 in line with available capacity.

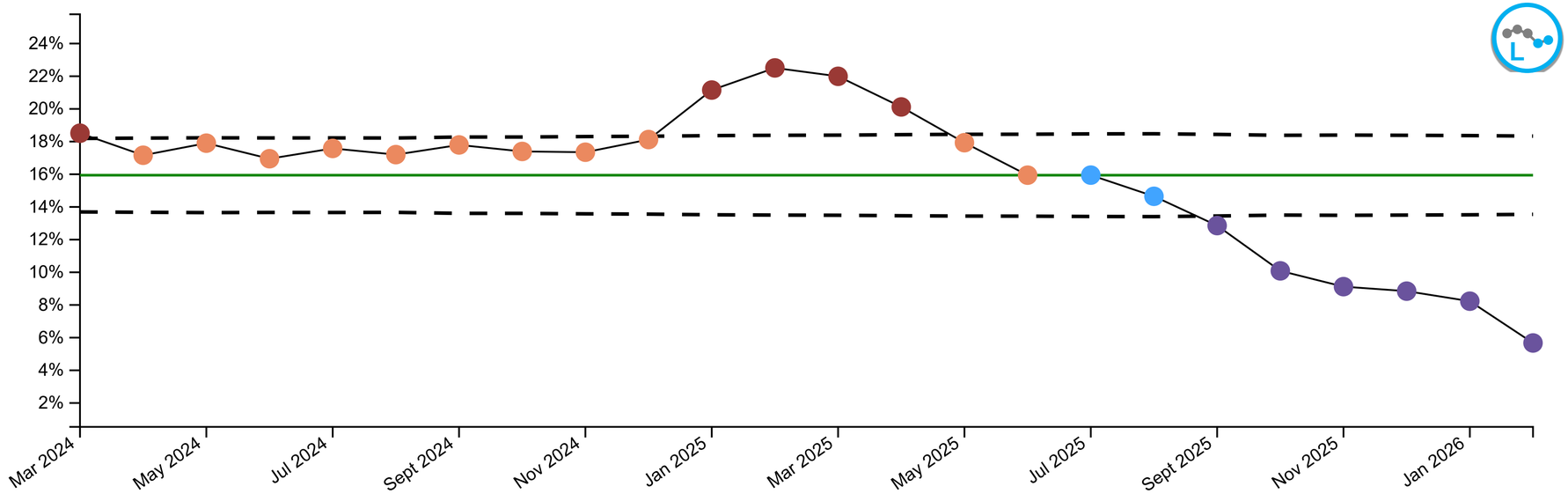
EndOfMonth	Waiting Over 52 Weeks
28/02/2026	270
31/01/2026	327
31/12/2025	579
30/11/2025	829
31/10/2025	806
30/09/2025	875
31/08/2025	1184
31/07/2025	1033

Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

TTG - Over 52 Weeks

u-Chart: Number of Inpatients waiting over 52 weeks



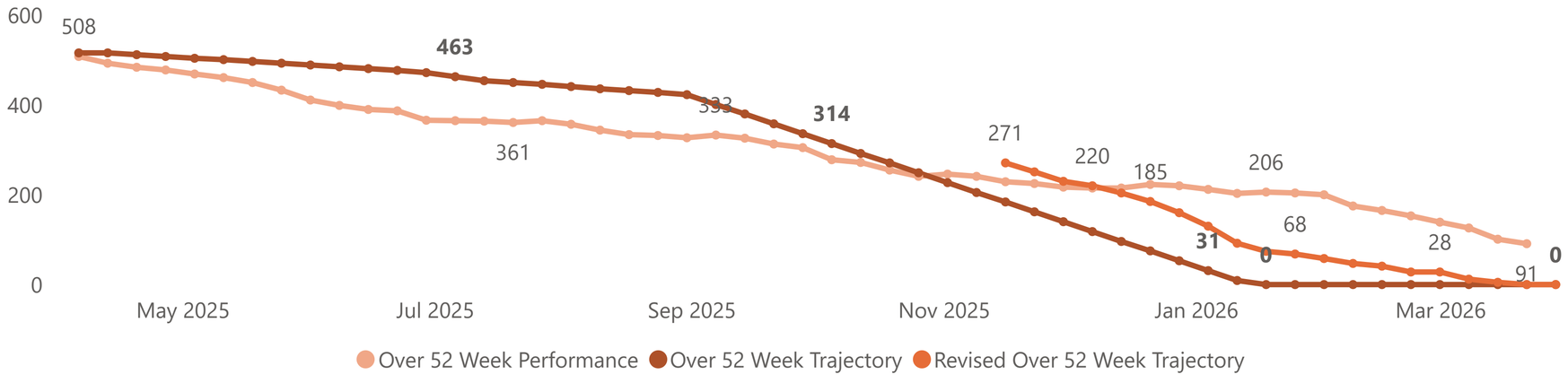
Mean Line — 99% Limits - - - - - - Imp. Trend Det. Trend Imp. Ast. Point Det. Ast. Point Imp. Shift Det. Shift

Month

February 2026

The data shows improving performance (Astro point) but is off trajectory. Data continues to demonstrate significant improvement. All specialties with one exception has or will have by 31 March eliminated all 52-week waits for treatment. Specific actions in targeted specialties continues in order to deliver against the key objective creating additional capacity and optimising available theatre and workforce capacity, with significant daily oversight of performance delivery.

Performance against Trajectory



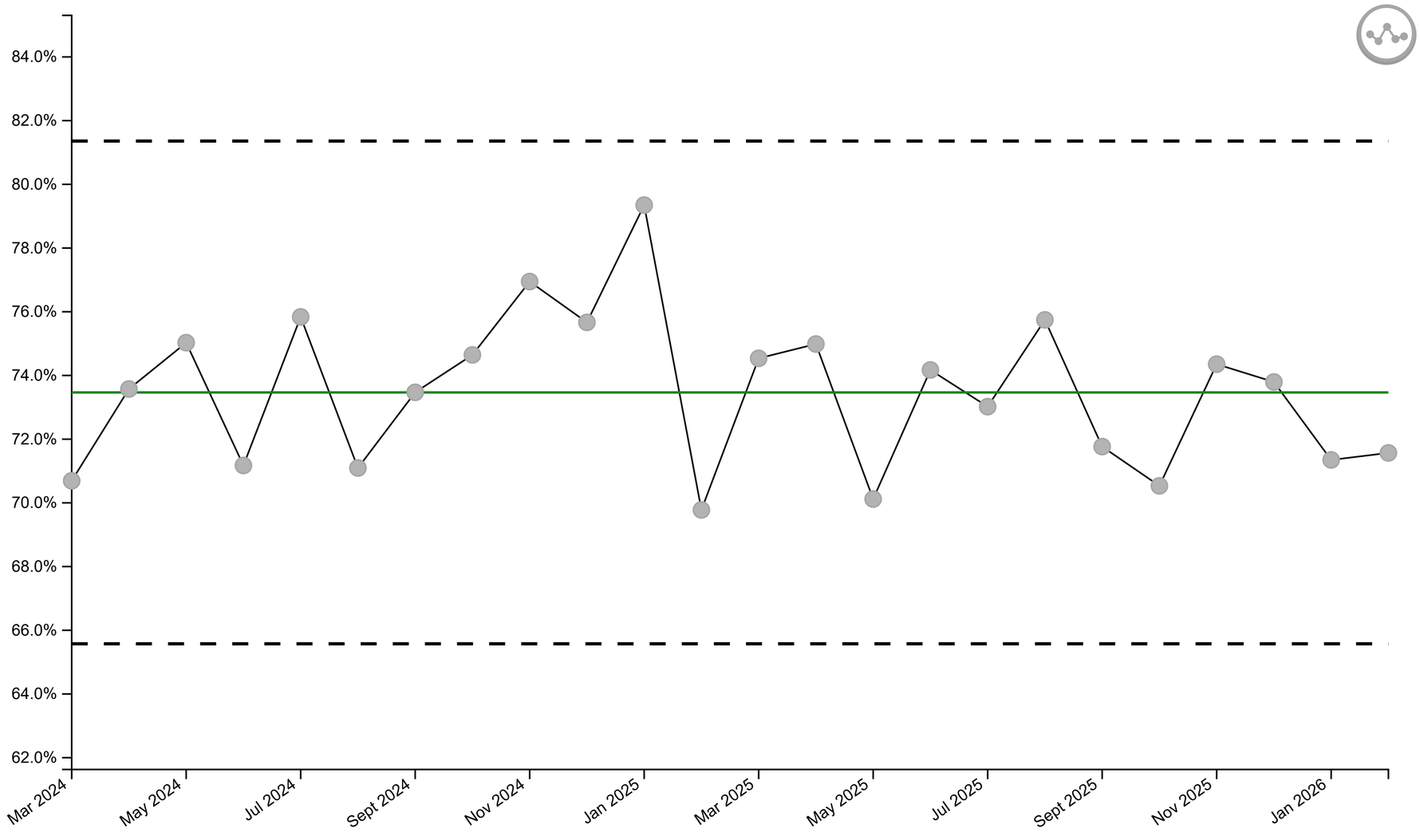
EndOfMonth	Waiting Over 52 Weeks
28/02/2026	142
31/01/2026	201
31/12/2025	213
30/11/2025	217
31/10/2025	243
30/09/2025	296
31/08/2025	327
31/07/2025	358

Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

Theatre Utilisation

i-Chart: Theatre Utilisation per month. Elective only, excludes theatre 5



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Month

February 2026

The data shows normal variation.

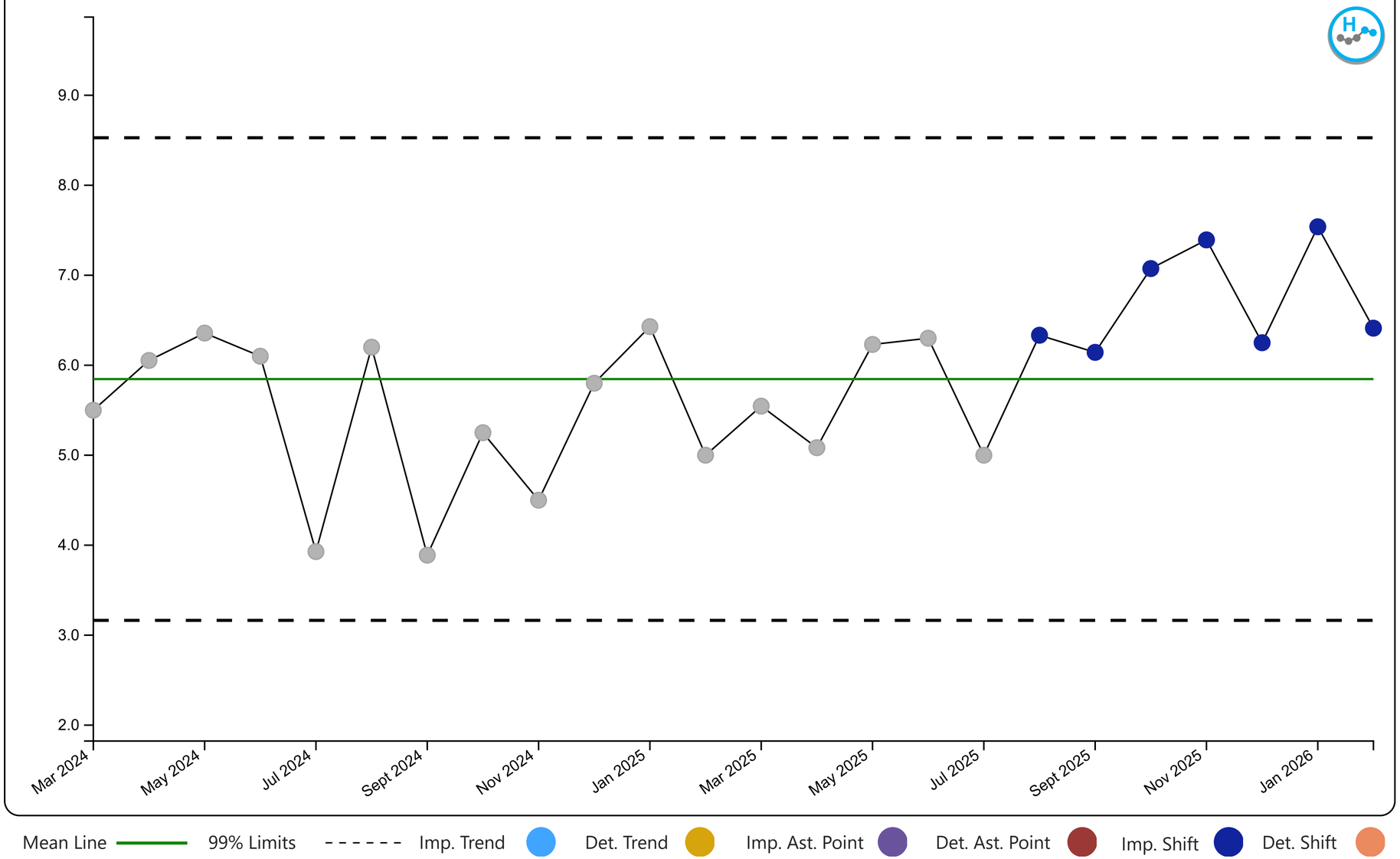
MonthEnding	Utilisation %
28/02/2026	71.6%
31/01/2026	71.3%
31/12/2025	73.8%
30/11/2025	74.4%
31/10/2025	70.5%
30/09/2025	71.8%
31/08/2025	75.7%
31/07/2025	73.0%

Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

Theatre - Cataract Cases

i-Chart: Average number of cataract cases per session



Month

February 2026

The data shows normal variation.

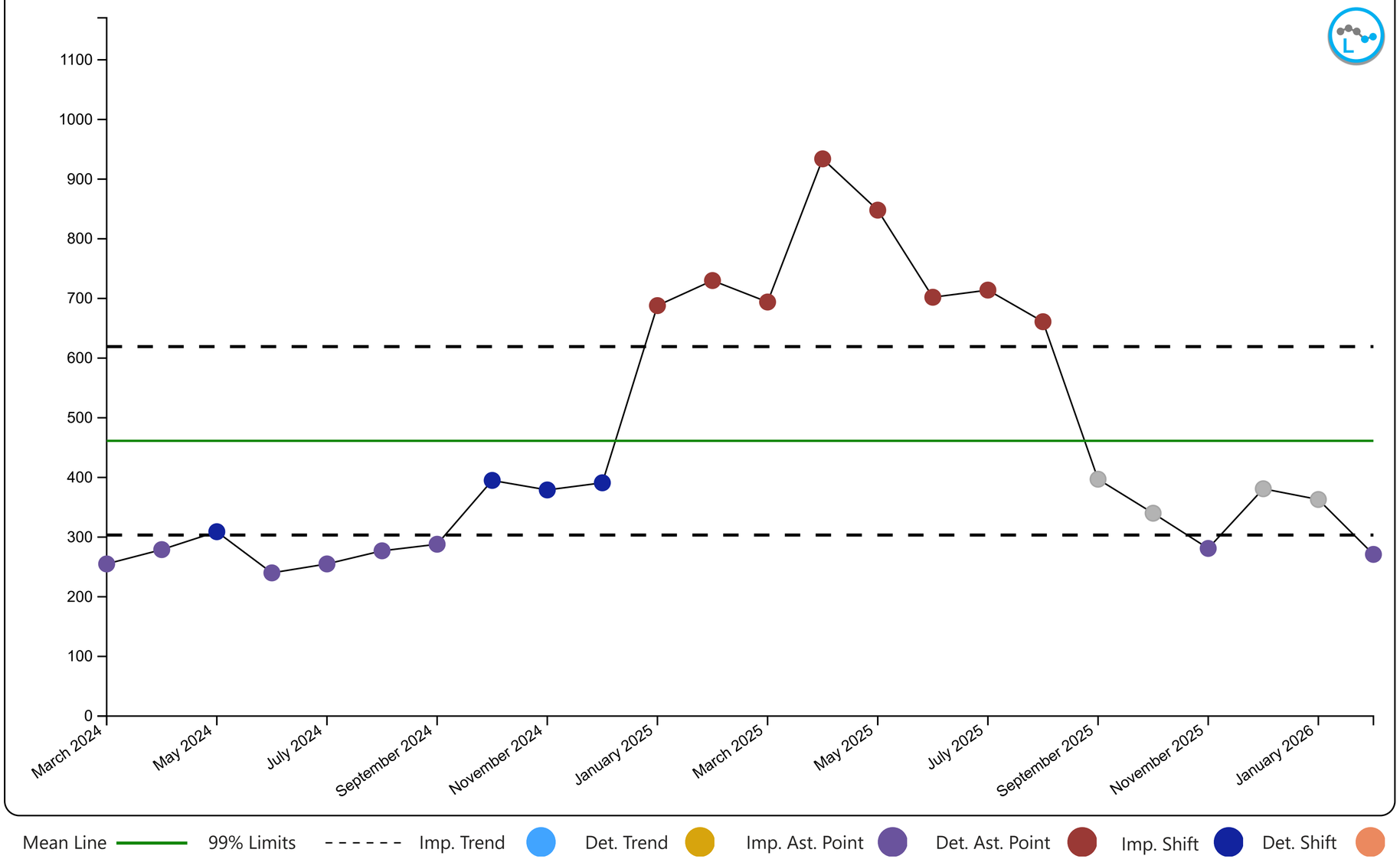
MonthEnding	Sessions	Cataract Cases	Average per Session
28/02/2026	17	109	6.4
31/01/2026	26	196	7.5
31/12/2025	24	150	6.3
30/11/2025	28	207	7.4
31/10/2025	27	191	7.1
30/09/2025	14	86	6.1
31/08/2025	12	76	6.3

Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

Diagnostic Waits Over 6 Weeks

i-Chart: Patients waiting over 6 weeks for diagnostic services



Month

February 2026

The data shows normal variation. Data demonstrates a significant reduction since its peak in April 2025 of patients waiting in excess of 6-weeks for a diagnostic against the reportable modalities, and the improvement has continued in February. Significant oversight of performance delivery and the implementation of the improvement plan for non-obstetric ultrasound continues.

Month/Year	Patients Waiting
February 2026	271
January 2026	363
December 2025	381
November 2025	281
October 2025	340
September 2025	397
August 2025	661
July 2025	714

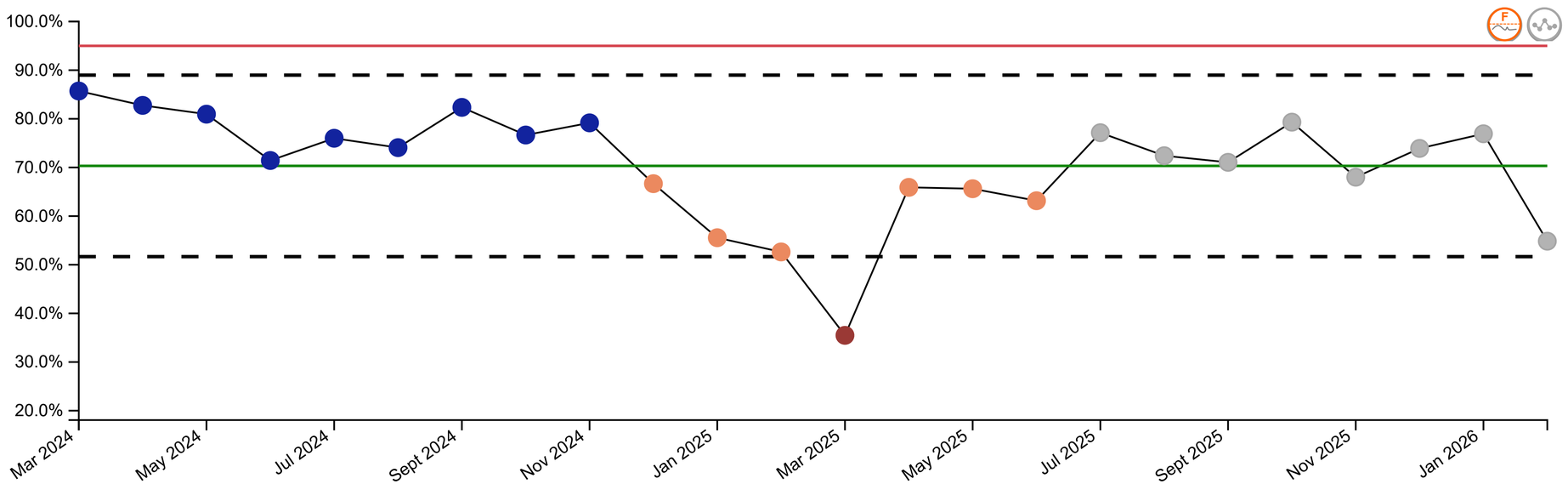
Integrated Performance Dashboard - Cancer Care

NHS Borders

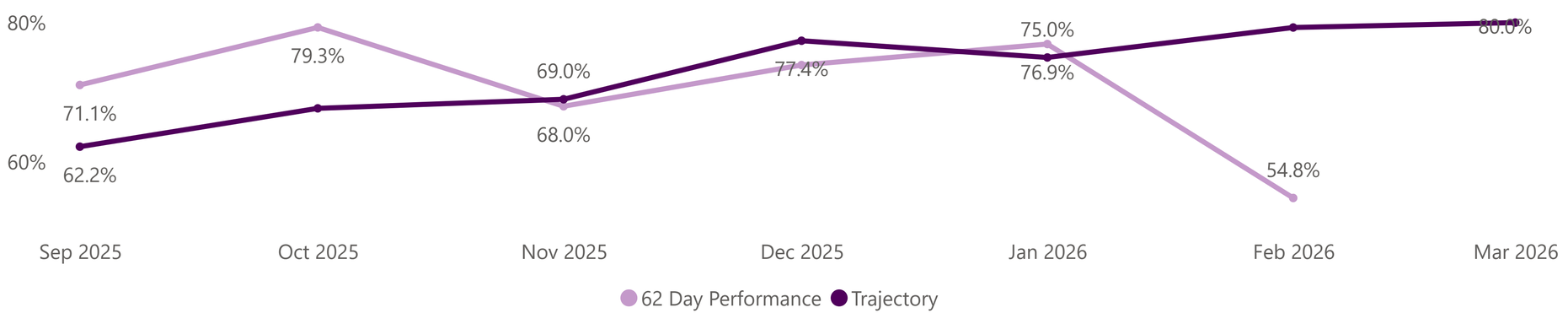
Lead Director: Oliver Bennett

Cancer - Treated within 62 Days

i-Chart: Percentage of patients treated within 62 days of referral



Performance against Trajectory



95% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

February 2026

The data shows normal variation and is on trajectory. Significant deterioration in performance in February due to service deliv and workforce challenges mainly in prostate cancer which mainly resulted in diagnostic delays and in some instances delays in treatment. Action has been taken to address the issues but there is a considerable lead in time and performance in March whilst expec to improve will remain below the annual tren

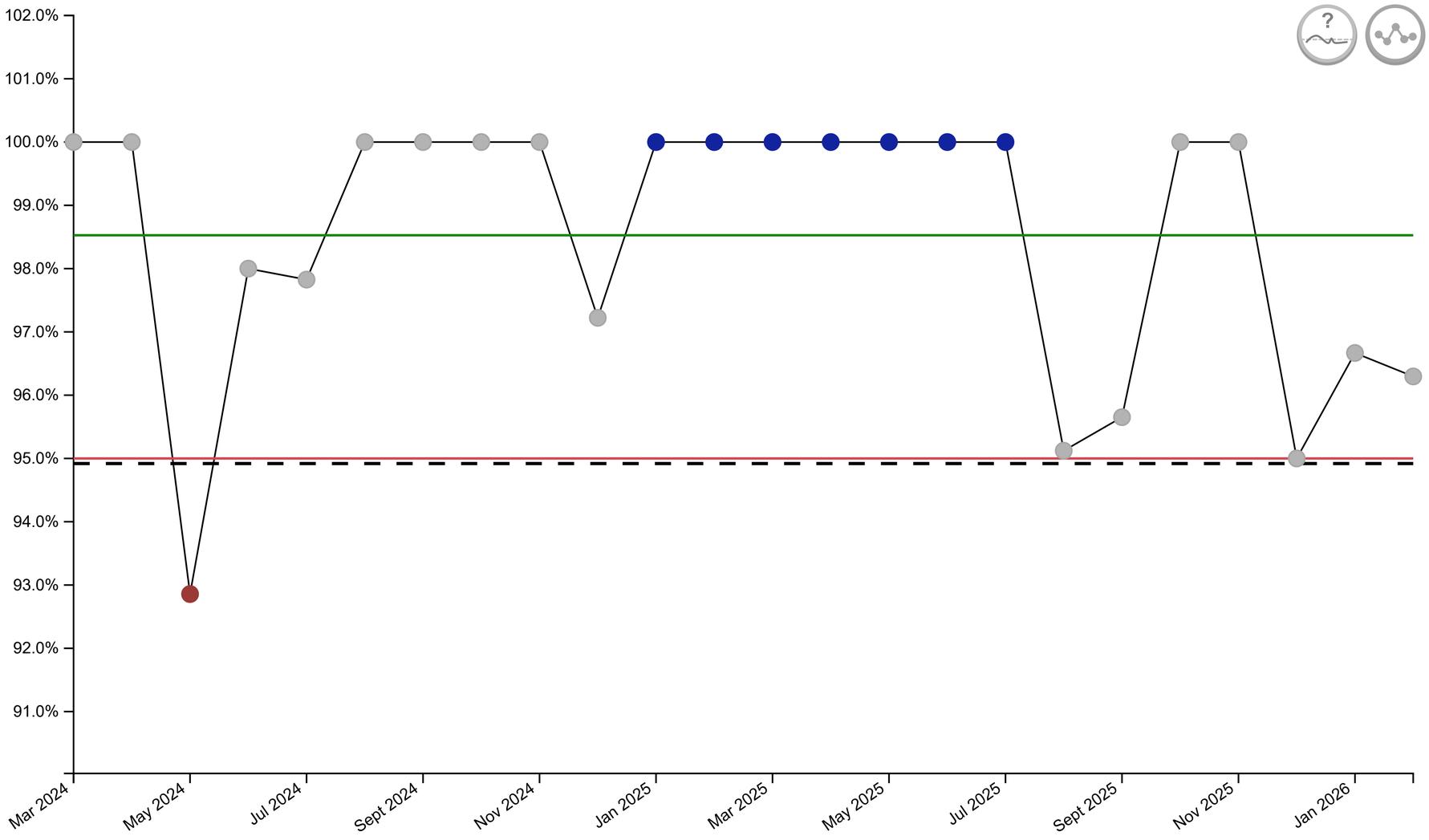
Treat Month	62Day%
February 2026	54.8%
January 2026	76.9%
December 2025	73.9%
November 2025	68.0%
October 2025	79.3%
September 2025	71.1%
August 2025	72.4%

Integrated Performance Dashboard - Cancer Care

Lead Director: Oliver Bennett

Cancer - Treated within 31 Days

i-Chart: Percentage of patients treated within 31 days



95% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

February 2026

The data shows normal variation. Data shows normal variation and overall static performance in February compared to January.

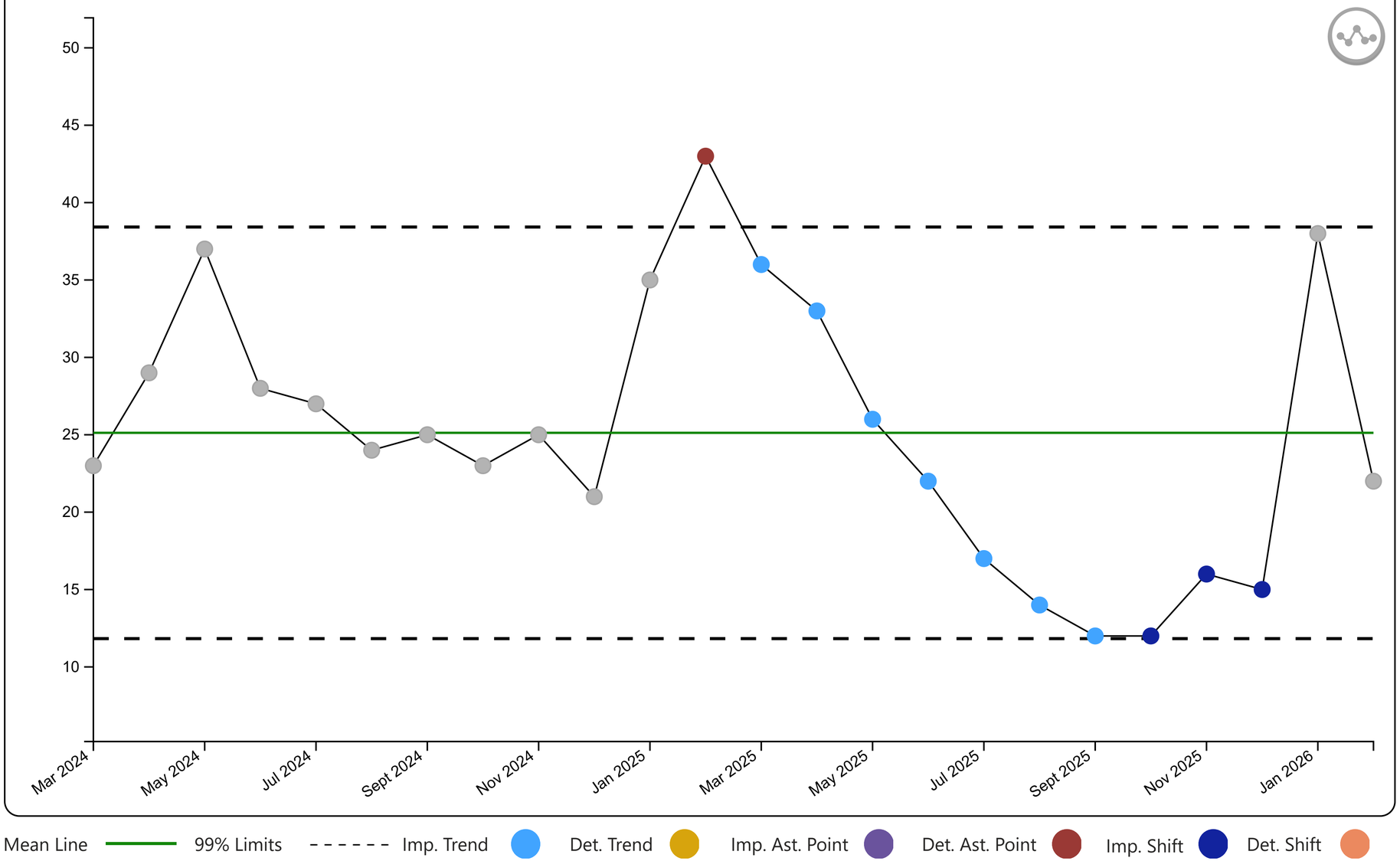
Treat Month	31Day%
February 2026	96.3%
January 2026	96.7%
December 2025	95.0%
November 2025	100.0%
October 2025	100.0%
September 2025	95.7%
August 2025	95.1%

Integrated Performance Dashboard - Cancer Care

Lead Director: Oliver Bennett

Cancer - Backlog

i-Chart: Number of patients waiting over 62 days for treatment



Month

February 2026

The data shows normal variation. Following a sharp increase in the 62D backlog in January, it has seen a dramatic fall in February although not fully recovered. Because of the immediate actions taken, inc. substantial increase in dermatology capacity and micormanagement of treatments, performance in March is expected to further improve.

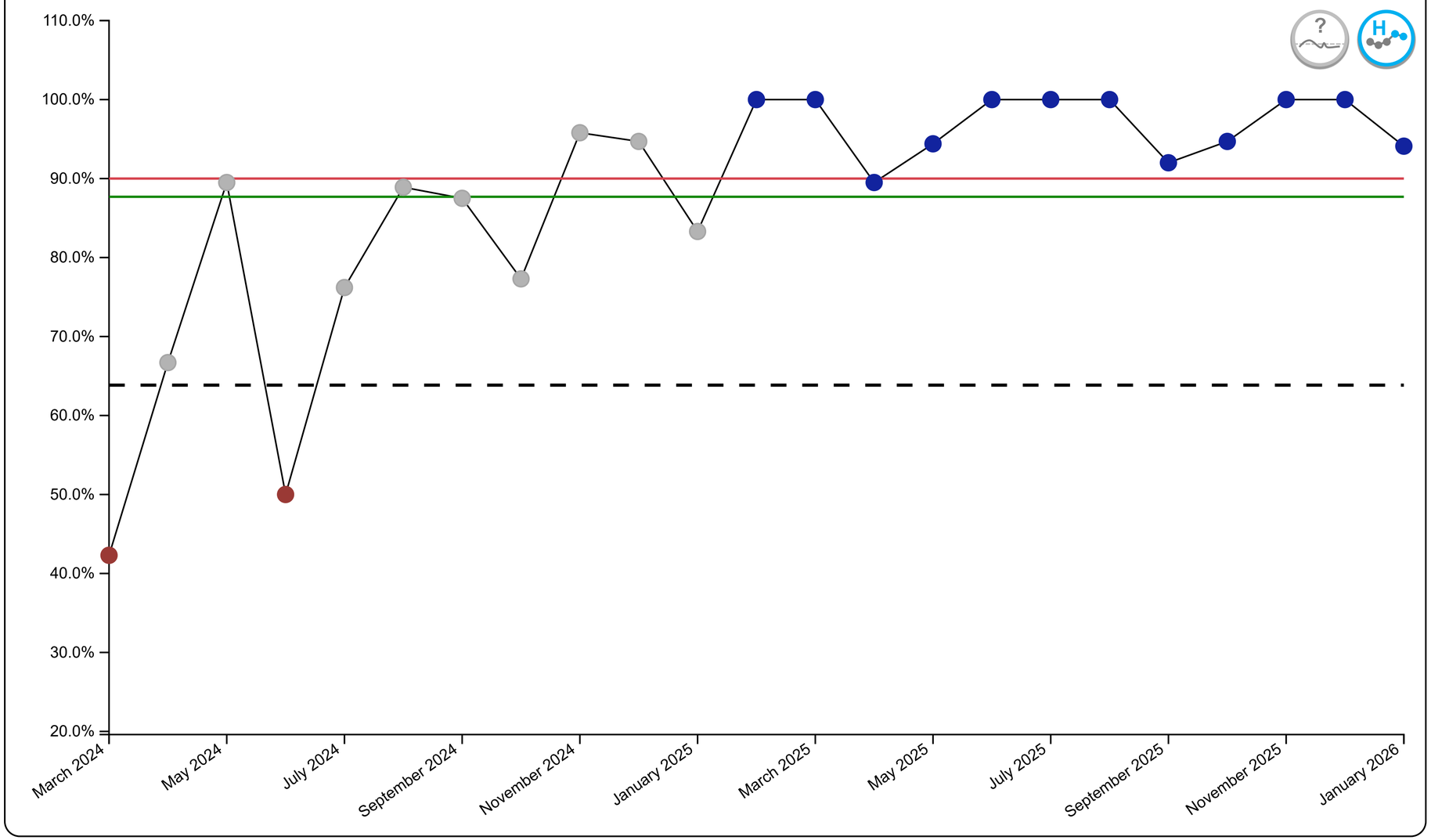
MonthEndDate	Total Backlog
28/02/2026	22
31/01/2026	38
31/12/2025	15
30/11/2025	16
31/10/2025	12
30/09/2025	12
31/08/2025	14
31/07/2025	17

Integrated Performance Dashboard - Mental Health

Lead Director: Gareth Clinkscale

CAMHS RTT

i-Chart: Percentage of Patients Received Treatment within 18 weeks of Referral



90% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

February 2026

The data shows improving performance (Shift). The data show we are consistently meeting target. Category 2 currently has 52 patient waiting, the average wait is 6 weeks. Over the past year CAMHS has consistently met the 90% target, with an impressive average achievement of 95.9%. CAMHS are projecting a 100% RTT target for the next reporting period. CAMHS remains steadfast in our commitment to providing ongoing support and ensuring the best possible outcomes for our patients.

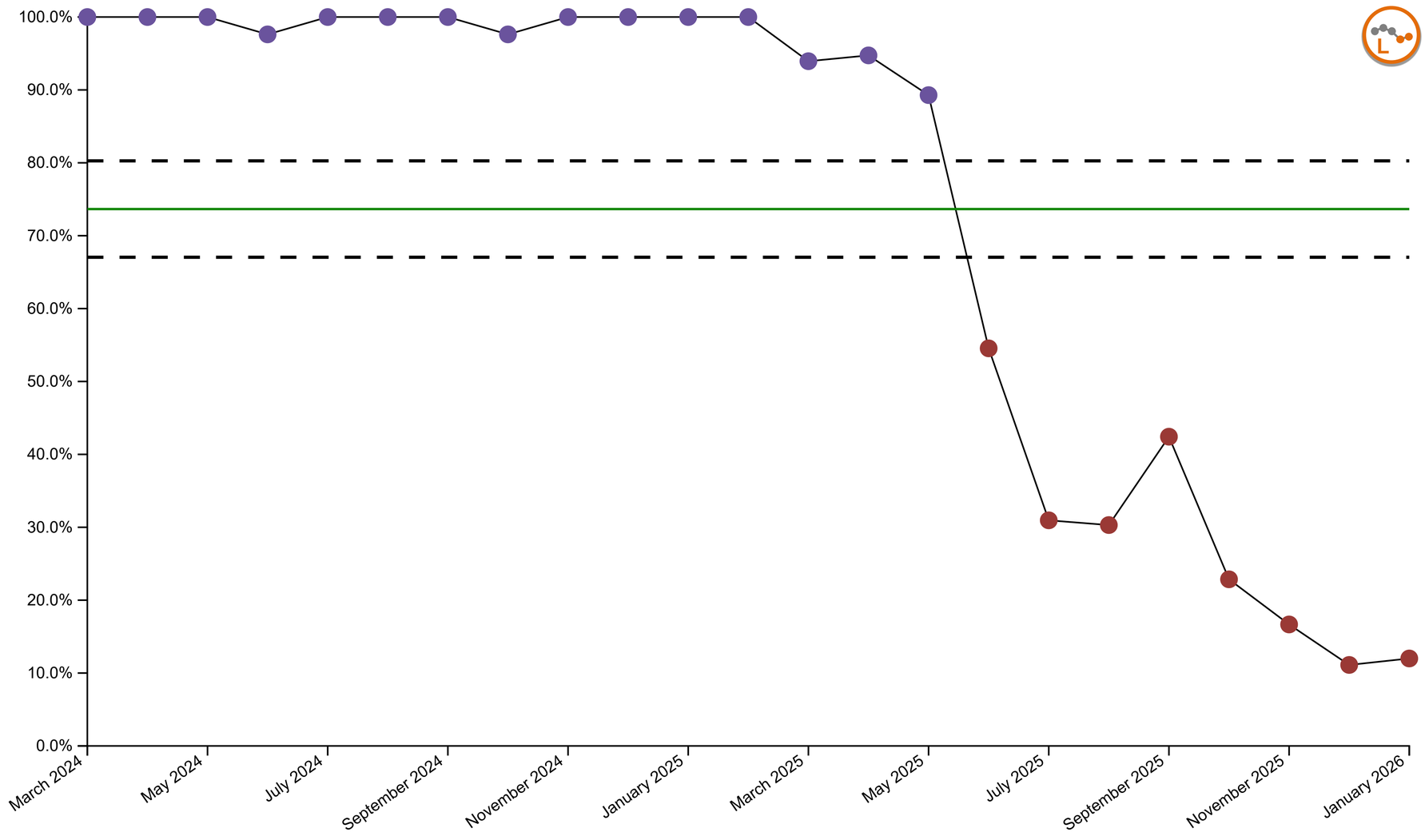
Month	Treatment %
January 2026	94.10%
December 2025	100.00%
November 2025	100.00%
October 2025	94.70%
September 2025	92.00%
August 2025	100.00%
July 2025	100.00%

Integrated Performance Dashboard - Mental Health

Lead Director: Gareth Clinkscale

CAMHS CAT 1

i-Chart: Percentage of Neurodevelopmental Waits seen within 52 weeks



90% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

February 2026

The data shows worsening performance (Astro point). Category 1 currently has 485 patients waiting for 1st assessment and 308 waiting internally. An internal waiting list initiative is underway to support those waiting internally and so far 176 patients have been removed and a further 30 have received appointments. This initiative continues to further reduce the backlog and improve access for those needing CAMHS assessment and support. Please note data has a 1 month lag time.

Month	Treatment %
January 2026	12.00%
December 2025	11.11%
November 2025	16.67%
October 2025	22.86%
September 2025	42.42%
August 2025	30.30%
July 2025	30.95%

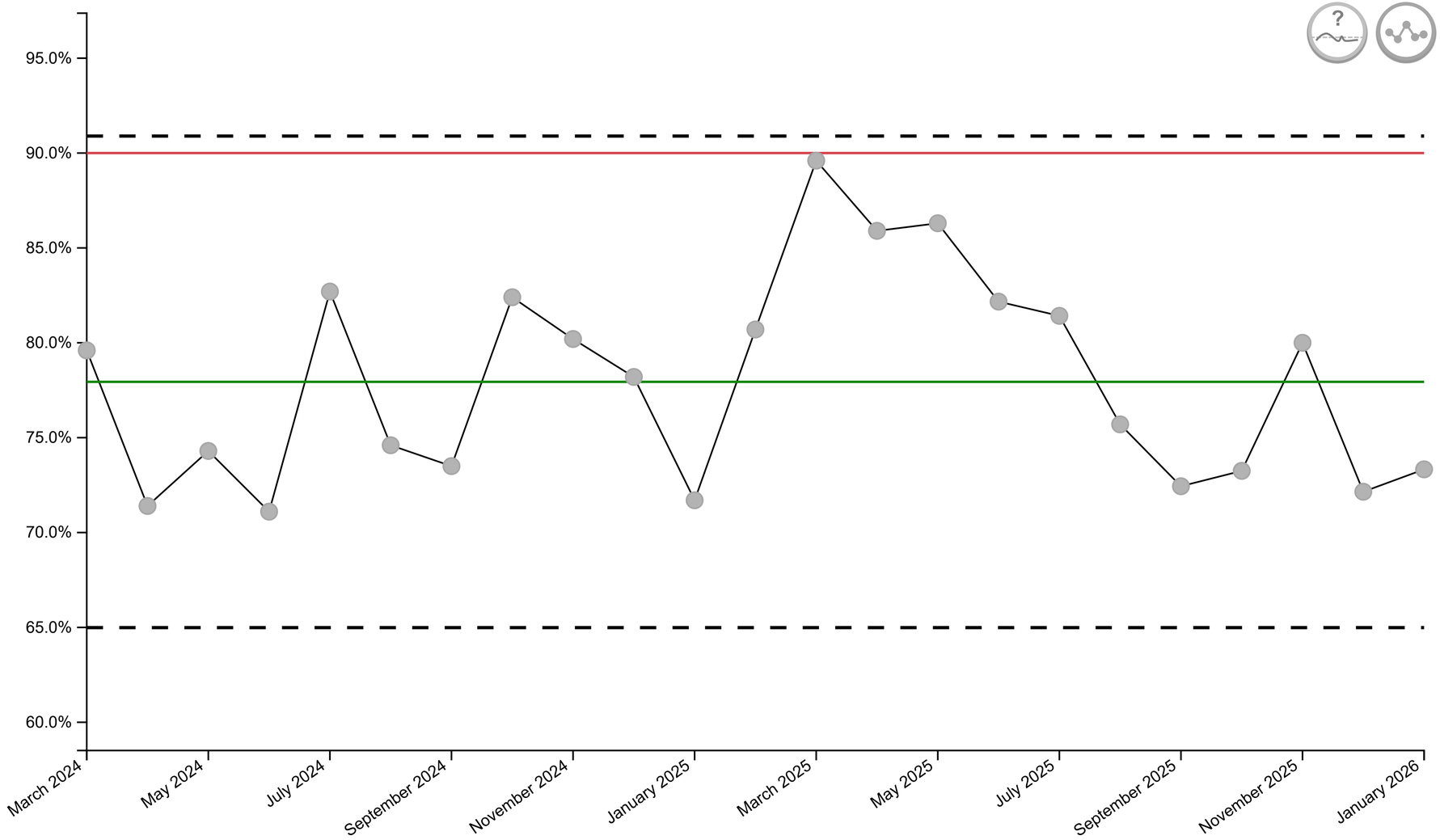
Integrated Performance Dashboard - Mental Health

NHS Borders

Lead Director: Gareth Clinkscale

Psychological Therapy

i-Chart: Percentage of Patients Received Treatment within 18 weeks of Referral



Month

February 2026

The data shows normal variation.

Month	Treatment %
January 2026	73.3%
December 2025	72.2%
November 2025	80.0%
October 2025	73.3%
September 2025	72.4%
August 2025	75.7%
July 2025	81.4%

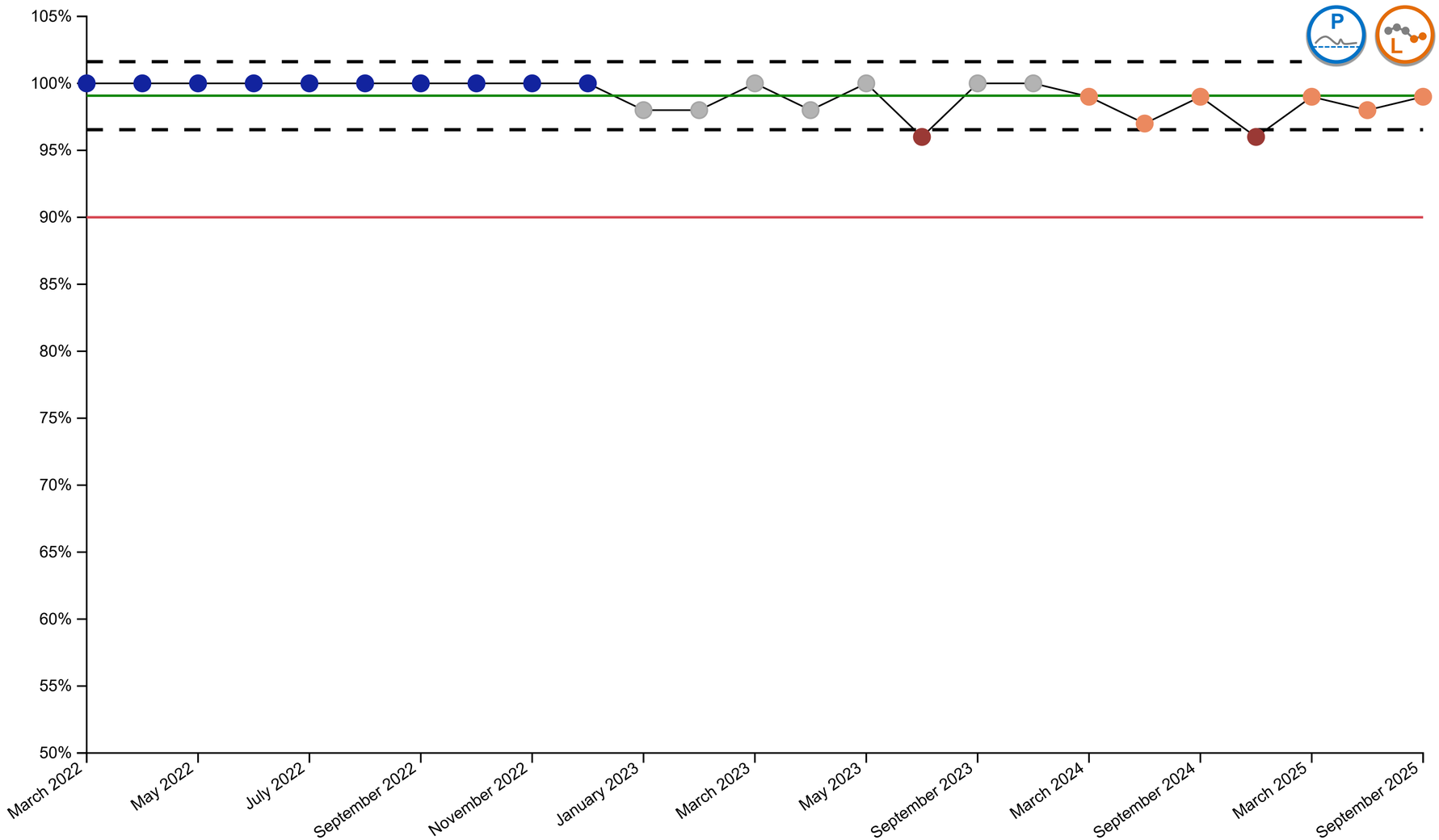
90% Target — Mean Line — 99% Limits - - - - - - Imp. Trend ● Det. Trend ● Imp. Ast. Point ● Det. Ast. Point ● Imp. Shift ● Det. Shift

Integrated Performance Dashboard - Mental Health

Lead Director: Gareth Clinkscale

BAS 3 Week Target

i-Chart: Percentage of Patients Received Treatment within 3 weeks of Referral



90% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

February 2026

The data shows normal variation.

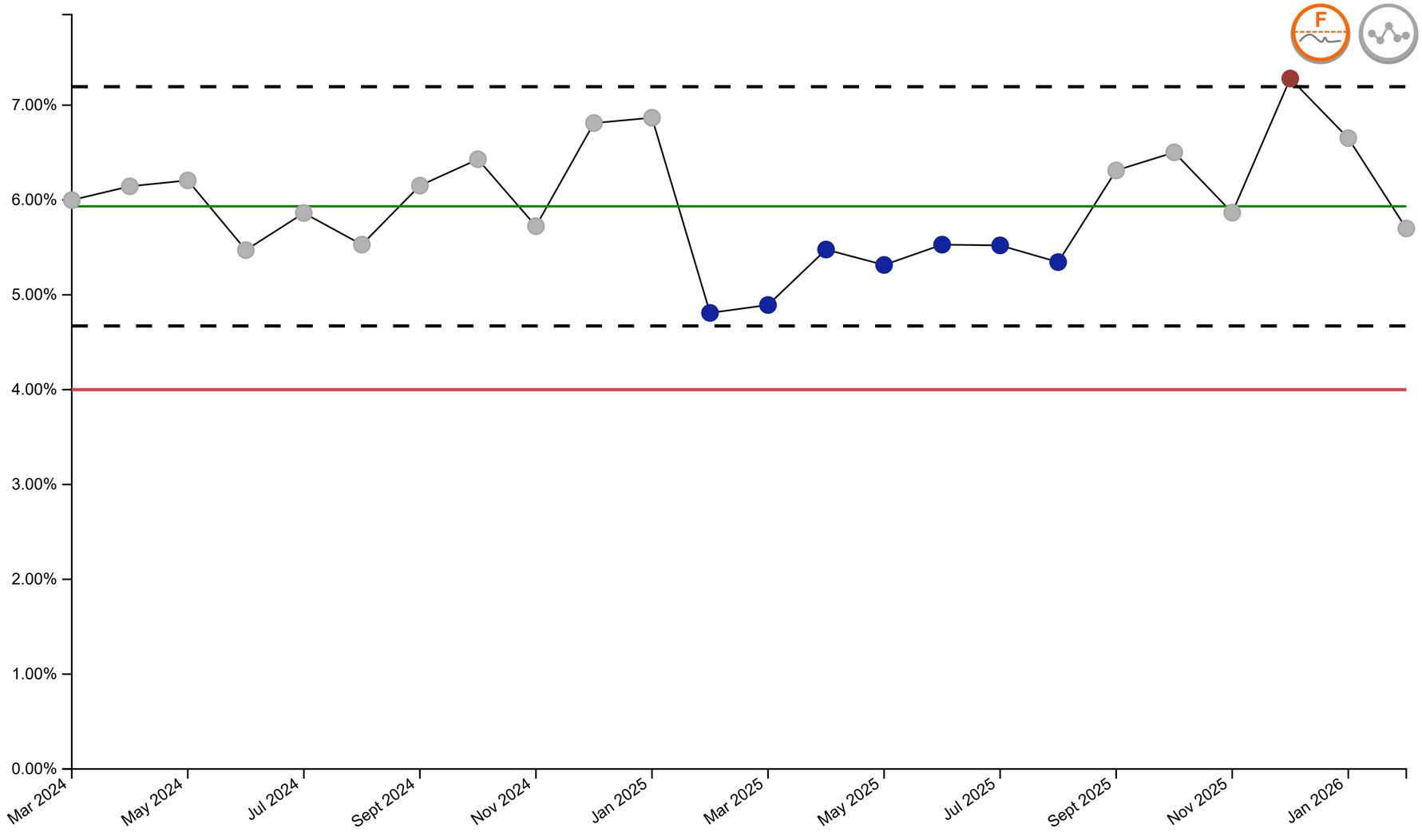
Date	Treatment %
September 2025	99%
June 2025	98%
March 2025	99%
December 2024	96%
September 2024	99%
June 2024	97%
March 2024	99%

Integrated Performance Dashboard - Workforce

Lead Director: Vacant

Workforce Absence

i-Chart: % of Hours Lost for all Departments per Month



4% Target — Mean Line — 99% Limits - - - - - - Imp. Trend — Det. Trend — Imp. Ast. Point — Det. Ast. Point — Imp. Shift — Det. Shift

Month

February 2026

The data shows normal variation.

Month	Absence Rate
February 2026	5.70%
January 2026	6.65%
December 2025	7.28%
November 2025	5.87%
October 2025	6.50%
September 2025	6.31%
August 2025	5.34%

Integrated Performance Dashboard - Methods & Sources

NHS Borders

Number	Topic or Page	Report Element	Indicator Name	Indicator Description	Data Source or Calculation	Known Issues	Refresh Schedule
	All Pages	Chart	Performance against Trajectory	Tracks measure performance against planned trajectory			
	All Pages	Table	Data table	Displays data table for measure			
	All Pages	Table	Narrative	Displays narrative for selected month and measure	Narrative Input		
1	Dashboard	Integrated Performance Dashboard	General Information	Style Guide Examples Dashboard	Source System: Internal table ; Vcontrol.xlsx	Does not contain examples of all visualisations	Weekly
1	Page: Urgent & Unscheduled Care - EAS	Chart: Emergency Access Standard	Emergency Access Standard	Percentage of patients seen within 4 hours	Tableau_ED		Weekly
2	Page: Urgent & Unscheduled Care - 8hr Breaches	Chart: 8 Hour Delays	8 Hour Delays	Number of patients waited over 8 hours	Tableau_ED		Weekly
3	Page: Urgent & Unscheduled Care - 12 hr Breaches	Chart: 12 Hour Delays	12 Hour Delays	Number of patients waited over 12 hours	Tableau_ED		Weekly
4	Page: Urgent & Unscheduled Care - LoS	Chart: Length of Stay	Length of Stay	Average length of stay. Non-elective only. Exlcudes peadiatric and obstetric specialties and ITU wards	Tableau_ADT		Monthly
5	Page: Urgent & Unscheduled Care - Occupancy	Chart: Acute Occupancy	Average Acute Occupancy	Average number of acute occupied beds per week	Tableau_WardMovements		Weekly
6	Page: Urgent & Unscheduled Care - DD's	Chart: Delayed Discharges	Delayed Discharges	Number of delayed discharges at the end of each week	Tableau_DelayedDischarges		Weekly
7	Page: Urgent & Unscheduled Care - Ambulance Handover	Chart: Ambulance Handover Time	Ambulance Handover Time	Average ambulance handover time in minutes per week	Whole Systems Pressures Dashboard		Monthly
8	Page: Planned Care - OP Waiting List	Chart: OP Waiting List	NOP - Over 52 Weeks	Number of outpatients waiting over 52 weeks	Tableau_WaitingList		Weekly
9	Page: Planned Care - IP Waiting List	Chart: IP Waiting List	TTG - Over 52 Weeks	Number of inpatients waiting over 52 weeks	Tableau_WaitingList		Weekly
10	Page: Planned Care - Theatres	Chart: Theatre Utilisation	Theatre Utilisation	% of theatre time utilised against planned session time. Elective only and excludes theatre 5.	Tableau_Theatres		Weekly
11	Page: Planned Care - Diagnostics	Chart: Diagnostic Waits	Daignostic waits over 6 weeks	Patients waiting over 6 weeks for diagnostic services	Diagnostics Return	Manually calculated figure	Monthly
12	Page: Cancer Care - 31 Days	Chart: Cancer - 31 Days	Cancer 31 Day Target	Percentage of patients treated within	Cancer WT Database (Excel)	Data subject to	Weekly

Integrated Performance Dashboard - Methods & Sources

Number	Topic or Page	Report Element	Indicator Name	Indicator Description	Data Source or Calculation	Known Issues	Refresh Schedule
13	Page: Cancer Care - 62 Days	Chart: Cancer - 62 Days	Cancer 62 Day Target	Percentage of patients treated within 62 days of referral	Cancer WT Database (Excel)	Data subject to updates	Weekly
14	Page: Cancer Care - Treaments	Chart: Cancer - Treated within 62 Days	Cancer Treated within 62 Days	Percentage of patients treated within 62 days of referral	Cancer WT Database (Excel)	Data subject to updates	Weekly
15	Page: Mental Health - CAMHS RTT	Chart: CAMHS RTT	CAMHS RTT	Percentage of patients received treatment within 18 weeks of referral	CAMHS Return	Manually calculated figure	Monthly
16	Page: Mental Health - Psychological Therapy	Chart: Psychological Therapy	Psychological Therapy	Percentage of patients received treatment within 18 weeks of referral	PT Return	Manually calculated figure	Monthly
17	Page: Mental Health - BAS	Chart: BAS	BAS 3 Week Target	Percentage of patients received treatment within 3 weeks of referral	BAS Return	Manually calculated figure	Quarterly
18	Page: Workforce - Total Absence	Chart: Workforce Absence	Total Workforce Absence	% of hours lost for all departments per month	HR Dataset		Monthly

Integrated Performance Report (IPR) – Development of Additional Measures

The IPR is in development and does not yet include all measures, it will be continually developed over the coming months to include the deliverables from the Organisational Strategy, the Annual Delivery Plan and other local Key Performance Indicatiors.

The table below shows progress on the development and the measures that will be included in the coming months.

Content	Commitment	Update
Quality & Safety		
• Adverse events • SAERs • Patient falls • Infection Control • Complaints • Care Opinion • Riddor reportable incidents • HSE investigations • FFP3 Fitting compliance • Risk compliance		In Progress - All data available and will be included in the IPR by March 2026.
W&CS		
Women & Children's Improvement Measures		To be developed by the service.
MH&LD		
P13: Implementing National Standards for Mental Health services - there are various initiatives around the standards due to be implemented in 25/26	ADP	Measure for improvement to be agreed with the service.
P14: LD Annual Health Checks	ADP	Aim for 26/27 when the service are confident they are accurately recording
Primary & Community Services		
Primary & Community Services Improvement Measures		To be developed by the service.
Public Health		

Healthcare Public Health • Total number of Did Not Attend and Cannot Attend out patients split by age/ sex/ SIMD **Health Improvement** • Child Poverty: % of Children living in low income families • Tobacco use: Smoking prevalence persons aged 16+ • Alcohol dependency and substance use: 'same day' prescribing for OST. The metric for Scotland is no one to breach 3 days, for rural boards it's not to breach 7 days. • Total number of individuals being supported by the Wellbeing Service, split by age / sex / SIMD **Health Protection** • Uptake of childhood immunisations at 24 months of age **Screening** • Uptake for Breast, Bowel, Cervical, AAA and DES screening		To be developed by the service. Information available however measures for improvement to be agreed.
Finance		
S7: 3% efficiencies	Organisational Strategy	In Progress
Financial Performance: target (within 1% of budget, excluding savings); variance by value (ytd, forecast)		To be developed
Savings: Overall target / forecast and YTD delivery. In addition, there are detailed milestones set within FIP programme and we should use these. They will change at each quarter.		To be developed
Agency staff expenditure: comparison with same YTD period for previous year (no target) – Medical; Nursing; Other		To be developed Measure for improvement to be agreed.
Cost Pressures: individual cost pressures with forecast value > £250k to be listed; mitigating actions identified.		To be developed
Cost per head of population: (budget/actual – annualised)		To be developed
Workforce		

S8: Ensure 100% of available staff receive an annual appraisal	Organisational Strategy	In Progress
S8: Ensure 100% of available staff complete Statutory & Mandatory training	Organisational Strategy	In Progress
• Overtime and Excess Hours • Management & Self-Referrals to Occupational Health • Coaching Interventions • Recruitment Overview • Detail on Hard-to-Fill Vacancies • Staff Turnover • HR Policy Activity • Exit Survey Learning • Staff Health Clearance compliance • OHS attendance/DNA • RTW compliance		To be developed. Information available however measures for improvement to be agreed.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Director of Public Health Annual Report**
Responsible Executive/Non-Executive:	**Dr Sohail Bhatti**
Report Author:	**Dr Sohail Bhatti supported by Kirsty Kiln**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Emerging issue

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

- Person Centred

2 Report summary

2.1 Situation

This is an independent professional assessment intended to inform strategic decision-making across NHS Borders and partner organisations. It sets out an overview of the health and wellbeing of children and young people in the Scottish Borders, highlighting the most pressing issues affecting outcomes across early years and adolescence and making recommendations. The Board is asked to comment on the recommendations and note the plan for publication of the report.

2.2 Background

An ageing population increasingly shapes strategic focus and service planning in NHS Borders. While this attention is necessary, it has meant that the needs of children and young people have, at times, received comparatively less system-wide oversight. The report highlights that, although older adults have rightly been a major priority, it is essential that the needs of children are not overshadowed within a region where their proportion of the population is smaller than the national average.

2.3 Assessment

Health inequalities take root long before a child reaches school age, and our own NHS Borders data show that these disparities are evident from birth. Local analysis demonstrates that maternal health, pre-conception wellbeing and early pregnancy behaviours strongly shape outcomes and can set diverging life-course trajectories from the very start.

Childhood is being reshaped by a set of rapidly emerging risks that intersect with, and often deepen, existing inequalities. Rising screen time and exposure to online harms are increasingly affecting sleep, attention, physical activity and mental wellbeing. At the same time, the normalisation of ultra-processed foods, reinforced by local high-street environments dominated by cheap, calorie-dense options, present significant threats to healthy growth, metabolic health and long-term weight outcomes, particularly for families facing financial constraint. The landscape of need is also shifting, with practitioners consistently reporting a rise in autism and wider neurodevelopmental concerns, alongside growing pressure within CAMHS and related pathways. These challenges demand whole-system responses.

2.3.1 Quality/ Patient Care

Not directly applicable

2.3.2 Workforce

Not directly applicable

2.3.3 Financial

The report sets out the challenges identified and sets recommendations for further exploratory work; there are currently no financial implications. That said, investing in prevention and early intervention is cost-saving to the system at large.

2.3.4 Risk Assessment/Management

Not directly applicable

2.3.5 Equality and Diversity, including health inequalities

At this stage, there is no need for an impact assessment. As plans are developed to take forward any recommendations, detailed impact assessments will be required.

2.3.6 Climate Change

Not directly applicable

2.3.7 Other impacts

Need to strengthen partnership approaches to ensure that whole-system change around children’s services and preventative activities is taken.

2.3.8 Communication, involvement, engagement and consultation

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

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

- Discussions with health visitors and school nursing representatives – Jan 2026;
- Discussions with colleagues in Education in SBC – Dec 2024 to date;
- Discussions with other children's services, including dietetics, Childsmile, Vaccination and Immunisation – Dec 2024 to date.

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.

- Not applicable – independent report

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**

3 List of appendices

The following appendices are included with this report:

Appendix No 1, Powerpoint overview of the report and its recommendations

NHS Borders

Our Future Selves

Improving the Health and Wellbeing of Children & Young People in the Scottish Borders

The Director of Public Health Annual Report

2025

Dr Sohail Bhatti | Director of Public Health

Purpose & Scope

- Provide an independent professional assessment to inform & challenge decision-making across the Scottish Borders. The Board has to receive the Report and take whatever action it deems from the recommendations. It is TO the Board, not the Board's report to itself.

- Focus on the health and wellbeing of children and young people in the Scottish Borders, with an emphasis on prevention across the life-course.

- Surface key challenges, inequalities and opportunities.

- Set out clear, actionable recommendations to improve outcomes.

The Population of Children & Young People

- The Scottish Borders has a comparatively smaller proportion of children and young people than Scotland overall. In 2022, the largest age group locally was those aged 45 to 64 (35,278 people), while young adults aged 16 to 24 formed the smallest group (9,456 people). With an ageing population, it is easy to give less attention to the relatively smaller proportion of children and young people but each has a family too….

- The Scottish Borders continues to experience a notably low birth rate, now well below the Scottish average. The area faces ongoing natural population decline, driven by sustained low fertility and an ageing population structure.

Concerted Action

My report sets out recommendations to strengthen how we meet the health and wellbeing needs of children and young people in the Scottish Borders.

- It starts with the need for clear governance and effective oversight, so responsibilities are defined and progress can be monitored.
- It calls for targeted action to reduce health inequalities.
- It emphasises shaping environments that enable healthy choices and promote healthy starts.

Health Inequalities

Health inequalities start before birth, are already evident by the time children begin school, and can persist throughout life. In the Scottish Borders:

- Health visitors report that **42% of children are growing up with a parent who has a mental health condition**, with higher rates in more deprived areas.
- Maternal smoking is highly influenced by socio-economic status. **30% of mothers in the most-deprived group are smokers** and only 1% in the least deprived group.
- **Maternal obesity affects 10% more mothers in the most deprived group**.
- There is also a **23.3 percentage-point gap between the most and least deprived areas in the proportion of children with a healthy weight.**
- For oral health, **57.4% of children in the most deprived group have no tooth decay**, compared with 84.9% in the least deprived group.
- Uptake of the HPV vaccine among S1 pupils is around **25% lower in the most deprived communities** than in the least deprived.

What people have told us…

Frontline professionals in the NHS, Education and Children's Services more widely have spoken with us. Consistent themes have emerged:

- Intervening early is vital, but services face rising complexity and demand
- Care-experienced children require consistent, trauma-informed and coordinated support, with clearer corporate parenting responsibilities across services.
- Emotional health and wellbeing needs are increasing among pre-adolescents and adolescents, contributing to anxiety, low mood, school avoidance. Parents of older children often lack accessible parenting support, despite increasing behavioural, emotional and developmental challenges during this time.
- System gaps, including fragmented community planning, limited neurodevelopmental pathways (especially 0–5), **and** significant workforce constraints, hinder coordinated responses to poverty of opportunity, unmet need and early identification.

Recommendations

1. Strengthen Governance for Children and Young People

- NHS Borders and Scottish Borders Council should embed the needs, rights and priorities of children and young people more explicitly within strategic decision-making structures and delegate funding to the correct joint leadership space, as a core element
- Revise the scope of the Integration Joint Board (IJB) to include children and young people. This would enable a unified direction and more effective use of finite resources. Clarity of roles and responsibilities will promote consistent planning, delivery & evaluation of services.
- Management of services should be overseen jointly rather than in organisational silos so whole systems thinking informs best outcomes rather than individual service priorities.
- Avoiding harm at this stage delays/prevents harm that we all pay for in older age…

2. Adopt a Whole System Approach to Children's Wellbeing

- Integration should move beyond siloed models of services; children's outcomes are shaped as much by their home, community and out of school environments as by formal services.
- Strengthening support for parents and carers must be a core priority, ensuring families are equipped to manage expectations, nurture wellbeing, and address emerging concerns collaboratively with schools and other services. We must work beyond schools into places

Recommendations

3. Amplify the Voice of Children and Young People

- The voice and lived experience of children and young people should have a stronger and more systematic role in shaping decisions, policy and service design. This includes embedding participation structures that influence, rather than simply inform, local decision-making.
- Real power is represented by the evidence of flow of funds, and budgets

4. Improve Understanding and Prevention for Excluded Groups

- Further work is required to understand the specific needs and risks experienced by learning disabled, care experienced children and other excluded groups. These small groups are at risk of being overlooked.
- Strengthening inclusive practice, safeguarding approaches and early intervention pathways is essential to preventing harm and reducing inequalities.

5. Identify and Support Young Carers More Effectively

- The local system should strengthen mechanisms to understand the scale and nature of caring responsibilities undertaken by children and young people.
- Improved identification, assessment and support are required to mitigate the hidden burden and its impact on education, wellbeing and future outcomes.

Recommendations

6. Embed ACEs Informed Practice and Strengthen Prevention

- The Borders should adopt a consistent, trauma-informed approach to the collection and use of Adverse Childhood Experiences (ACEs) data. This will support earlier identification of vulnerability, enable more proportionate allocation of limited resources, and strengthen prevention in the early years, where inequalities become deeply entrenched without timely action. This is primary prevention and needs coordinated action.
- We need to develop a means of collecting this data in a way that is sensitive to the needs and rights of children and provides appropriate support as required.

7. Deliver a Comprehensive Whole Family Support Offer

- The Scottish Borders should ensure a robust Whole Family Support system that provides emotional, practical and financial assistance. This includes ensuring consistent access to the Bairns' Hoose model, embedding trauma informed justice pathways, and delivering a clear local approach to preventing and addressing online harm.

8. Build Vaccine Confidence

- A coordinated, evidence-based response to rising vaccine hesitancy is needed, with clear public facing communication, trusted professional voices, and targeted support for communities where uptake is lowest.
- Misinformation around specific programmes, such as HPV, should be addressed.

Recommendations

9. Reduce the Pathologising of Childhood Variation

- Services should ensure clinical pathways do not unintentionally medicalise typical developmental variation. This includes careful response to rising identification of neurodivergence and evolving diagnostic thresholds for ADHD and autism, with a focus on supportive environments rather than default clinical labelling.
- Build capacity for parental self-help to address challenging behaviours
- Build care management capability within parents/guardians waiting for CAMHS assessment for their children

10. Create Health-Promoting Local Environments

- Planning, licensing and regulatory systems should be more responsive to children's health needs. This includes managing the proliferation of fast-food outlets, addressing obesogenic environments, and tackling the easy availability of harmful substances. A more preventative spatial planning approach is essential to safeguard children's long-term health.

Recommendations

11. Reducing screen-time and promoting healthy routines

- Strengthen support for parents and carers to establish healthy screen-use routines for children and young people. This should include providing clear, evidence-based guidance on recommended screen time limits for different ages, and tailored support for those facing additional pressures such as parental stress, financial strain or limited access to alternative activities.

12. Build intergenerational initiatives to support better community outcomes

- More atomised families leads to greater isolation and misunderstanding; by working across the generations everyone can benefit in better community outcomes

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Integration Joint Board Minutes**
Responsible Executive/Non-Executive:	**P Moore, Chief Executive**
Report Author:	**I 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 18 March 2026

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Integration Joint Board minutes 21.01.26

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 21 January 2026 at 10am** via Microsoft Teams

Present:

(v) D Parker (Chair)
(v) R Tatler
(v) E Thornton-Nicoll
(v) T Weatherston
(v) N Richards
(v) L O'Leary, Non-Executive
(v) J Ayling, Non Executive
(v) F Sandford, Non-Executive
L Turner, Chief Financial Officer
R Duncan GP
L Jackson, LGBTQ+
N Hood, Borders Carers Centre
N Istephan, Chief Executive, Eildon Housing Association
S Horan, Director of Nursing, Midwifery & AHPs
J Smith, Borders Care Voice
D Bell, Staff Side, SBC
J Amaral, Chief Executive, Borders Community Action

In Attendance:

I Bishop, Board Secretary
P Moore, Chief Executive, NHS Borders
D Robertson, Chief Executive, Scottish Borders Council
K Steward, Community Nurse Manager, NHS Borders
C Myers, Director of Adult Social Work & Care
J Glen, Scottish Borders Council
S Pow, Scottish Borders Council
A Bone, Director of Finance, NHS Borders
M Fleming, Finance Manager, SBC
S Bhatti, Director of Public Health, NHS Borders
G Clinkscale, Interim Director of Urgent Care, Community Services & Mental Health, NHS Borders
L Jones, Director of Quality & Improvement, NHS Borders
C Oliver, Head of Communications, NHS Borders

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from L McCallum, Medical Director, J McLaren, Non Executive, J Stacey, Chief Internal Auditor and S Burt, Chief Social Work Officer.

1.2 The Chair welcomed attendees and members of the public to the meeting.

1.3 The Chair advised that interviews were scheduled for February for the appointment of a Chief Officer.

1.4 The Chair confirmed that the meeting was quorate.

1.5 In terms of agenda items, the Chair signalled a forthcoming discussion regarding the recently published Audit Scotland national report on delayed discharges. It was noted that J Stacey had corresponded to suggest that the report be reviewed before the Audit Committee meeting scheduled for 23 March 2026. The Chair indicated that a development session may be required to fulfil that obligation and that the matter would be addressed in more detail under 'Any Other Business' later in the meeting.

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 held on 24 September 2025 were approved.

4. MATTERS ARISING

4.1 S Bhatti requested that it be formally noted that M Muir, who delivered the presentation on item 8 at the previous meeting, had since been appointed as Deputy Chief Dental Officer for a three-month period. This appointment was significant as it was intended to offer the Chief Dental Officer's office insight into the particular challenges faced by rural and remote boards, such as NHS Borders.

4.2 L Jackson highlighted the equality human rights and Fairer Scotland duty update previously mentioned by J Amaral. She was concerned that since W Henderson had concluded her appointment there had been no requests for equality impact assessment involvement, whereas previously there were many. She was not confident that the organisation was compliant with the Fairer Scotland duty. The Chair commented that it was likely that the lack of a Chief Officer had slowed down the process.

4.3 J Amaral raised the request for an agenda item, specifically regarding ministerial consultation on IJB voting rights. She noted that the matter had been included in the agenda pack, but was disappointed to see it categorised under "Any Other Business" given it was a significant governance issue, particularly for the third sector, as it related to amendments to the Integration Joint Boards (Scotland) Order 2014. She was interested to know whether the Board was fully aware of the process which began in 2021, including consultations attended in person by some members in 2023, culminating in a ministerial letter to IJBs in November 2025. To her knowledge, the Board had the opportunity to respond. Earlier in the month, the Order was published in the Scottish Parliament alongside the Equality Impact Assessment. Her key request was clarification on the Board's awareness of those changes, especially given the lack of background provided in the agenda. Furthermore, she recommended that the Board formally log an action to develop a practical paper outlining the implications of those changes, emphasising the third sector's role in decision-making and agenda setting across all IJBs in Scotland. she urged that the item be reinstated on the agenda at the earliest possible opportunity, with input from the third sector to illustrate how those changes would function in practice.

Additionally, she requested the new Chief Officer make it a priority to engage with the third sector to discuss meaningful participation moving forward.

4.4 The Chair commented that the lack of a Chief Officer had obviously impacted on the ability of the IJB to respond to the consultation. The position of NHS Borders and Scottish Borders Council had been shared, but a response from the IJB had not been agreed. He was aware that the Minister had written to tell everybody what the outcome had been and regulation on how the changes would work in practice were awaited. He suggested the Chief Officer bring a paper to a future IJB meeting once regulation was received.

4.5 **Action 2024-7:** L Jones commented that the hospital at home service was progressing well. A broader paper on urgent and unscheduled care would be prepared and scheduled for the March IJB meeting, where the aim would be to close the action.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed a paper on IJB Voting Rights be brought to the Board as soon as regulation and guidance was released.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the Action Tracker.

5. PERFORMANCE AND DELIVERY REPORT

5.1 The Chair advised that whilst the Chief Officer position remained vacant the Performance & Delivery Report had been formulated as per normal processes in order to ensure the Board maintained an oversight of progress within certain activities.

5.2 Any questions in regard to the content of the report could be emailed to I Bishop who would source answers outwith the meeting.

5.3 L O'Leary requested that the up to date Directions Tracker be issued to the Board for information.

5.4 P Moore acknowledged the collaborative efforts between health and social care in improving delayed discharge performance. Compared to the previous year, numbers had halved despite significant operational pressures. The positive changes across NHS Borders services, Scottish Borders Council services and support from the voluntary sector were noteworthy and had all contributed to the improvement.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive the up to date Directions Tracker via email.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the Performance and Delivery Report.

6. IJB BUSINESS PLAN AND MEETING CYCLE 2026

6.1 I Bishop confirmed that the report outlined 6 IJB meetings, 4 Audit Committee meetings, and 6 Strategic Planning Group meetings for the coming year. The

schedule mirrored the previous year, and the business plan included all expected items. Once the Chief Officer was appointed, some adjustments might be needed.

6.2 L Turner advised that the Annual Accounts were due to be signed off by the Board before the end of September and after the Audit Committee on 21 September. She asked that the Board meeting due on 16 September be moved to 30 September.

6.3 The Chair also asked that the Board meeting schedued for 15 July be moved to 5 August.

6.4 J Smith noted that the public sector equality duty was not due until 2027 and asked if a progress update could be provided to the Board to assure the Board that progress continued to be made.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the business plan and meeting cycle for 2026.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the moving of the IJB meeting on 16 September to 30 September.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the moving of the IJB meeting on 15 July to 5 August.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to request an update on public sector equality duty compliance.

7. IJB 2025/26 QUARTER 2 FINANCIAL MONITORING POSITION

7.1 L Turner provided an overview of the report and commented that the report used Quarter 2 figures since Quarter 3 data was not yet available; key messages had been updated to reflect the latest NHS and SBC positions. Table 2 showed the current budget for the IJB at £238m and £33.6m for set aside, which would increase due to new funding from the Scottish Government, including £3.4m for the Frailty Unit, Integrated Discharge Team, and recurring support for hospital-at-home programmes. Delegated services reported a £7.3m overspend at Quarter 2, up £2m from Quarter 1, with £3m attributed to the Council and £4.3m to the NHS. Increased service activity had improved performance but was financially unsustainable, prompting a review of care levels. Discussions continued about resource transfers for previously moved services. In regard to Set Aside the forecast of £7.8m pressure was slightly lower than Quarter 1. Table 5 included Carers Act spending, forecast at £1.9m, just over budget. Significant savings still needed to be achieved; updates would follow after Quarter 3. Quarter 2 reserves had a £9.3m balance (Table 8): £4.2m would be spent in 2025/26, £1.9m ring-fenced for future years, and the remainder was flexible. Ideally, those funds would drive transformation and address on-going financial pressures, though they may be needed elsewhere.

7.2 Discussion focused on: delivery of savings with most declared as underspends at Quarter 3 in SBC; fully supportive of reductions in care packages under 5 hours given the tendency to over prescribe care; recognition that delayed discharges are delayed people who are residents of the Scottish Borders; SBC are trying to ensure the ongoing sustainability of services within their resource envelopes; whenever we assess the impact of financial choices, an equality impact assessment is conducted to show that we are not worsening disadvantages for our communities; Significant

investment of £6 million, bringing together funders, redesign of services and reimagining a new future as a result of new delivery, new models of delivery; reconciling the coming home project because of the damage it does to very vulnerable people and the huge cost financially; to provide some reassurance to the Board part of the issues that are in Coming Home are wrapped up in the discussions that are taking place in the parent organisations about funding; and the potential for future lottery type funding.

7.3 The Chair enquired about progress sin regard to the formal request from the Council of a sum of money from the NHS, and he sought clarification on the status of those discussions. The Council was scheduled to set its budget on 19 February; if negotiations were not concluded prior to that date, there was a likelihood that the Council may withdraw the requested funds due to financial constraints. L Turner advised that meetings were scheduled and she was optimistic that an outcome would be achieved by the end of January.

7.4 The Chair advised that he had raised the point as he was keen to ensure the IJB was kept up to date in regard to the £2m gap, which could lead to reduced care packages if it remained unresolved.

7.5 P Moore commented on the need to ensure there was a sustainable model that was fully understood and effectively resourced over the long term. He also suggested there was a need to consider how to fund and sustain it more transformationally as organisations through collaboration across all stakeholders in the shared space.

7.6 D Robertson commented that it was essential to move away from viewing budget allocation as an annual exercise that resulted in last-minute surprises during May and June, especially after setting budgets just months prior. He and P Moore had already agreed to coordinate joint action on financial matters by the end of January to better integrate with the budgeting process. He highlighted that there was extensive work ongoing around leveraging data and technology to enhance care delivery across the region, including transformational services like 'hospital to home'. He was keen to achieve a more stable financial position and acknowledge the need for increased funding to match rising demand and expanded capacity. It is also important to ensure that care packages were sourced appropriately. As P Moore had previously noted, there remained some inefficiency within the system, and although addressing that may not entirely resolve the gap, further improvements were possible. In conclusion, he reassured the Board that matters were being actively addressed, with plans in place to feed into the budget process by the end of January. The goal was to establish a fair and equitable funding arrangement for delayed discharges that benefited all stakeholders involved.

7.7 The Chair enquired about the £3.4m received and spent this year on the Frailty Unit and related issues. He advised that a letter had been received from the Minister stating the funding could have come through the IJB, and in other areas, similar funds had been allocated between Councils and the NHS by IJBs. His understanding was that, in the Borders, it was used solely for NHS funding and he sought clarification.

7.8 L Turner clarified that the funding was managed quickly through the NHS, not the wider IJB. The NHS had since worked with SBC to redirect some funding where there was an underspend. She suggested taking a paper to the Unscheduled Care Board, which reviewed and oversaw the matter.

7.9 A Bone advised that in the Scottish Government's budget, there was an adjustment. It was the budget announced the previous week with an adjustment to the amount of money that was invested within what was the NHS operational improvement plan and the figure that was announced for 2025/26 from which the money referred to was funded was £200m nationally across both planned care and unscheduled care. The figure for next year had been adjusted to £100m and the implications of that were unknown. He expected over the next few weeks that there would be discussions with the Scottish Government around the recurrency of the commitments made this year which might bring a further financial concern to the table at that point. In the meantime services would be developed on the back of plans that had already been agreed. He highlighted concern at the risk over the level of funding that would be received on an on-going basis.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the forecast financial position of the IJB as at 30th September 2025.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the ongoing risk to the financial sustainability of the IJB due to current funding levels compared to running costs and demand and the anticipated impact of this in 2026/27.

8. AUDIT COMMITTEE MINUTES: 08.09.25

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

9. ANY OTHER BUSINESS

9.1 **National Audit Report:** The Chair advised that J Stacey had suggested the National Audit report into Delayed Discharges should be discussed by the IJB. He suggested a Development session be organised to discuss the report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to hold a Development session focused on the National Audit Report into Delayed Discharges.

10. DATE AND TIME OF NEXT MEETING

10.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 18 March 2026, from 10am to 12 noon through MS Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**23 March 2026**
Title:	**Code of Corporate Governance Sectional Refresh**
Responsible Executive/Non-Executive:	**A Bone, Director of Finance**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

To recommend the Board formally approve the sectional refresh of the Code of Corporate Governance (CoCG) as recommended by the Audit and Risk Committee.

2.2 Background

The Code of Corporate Governance details how the Board organises and governs its business.

The Code of Corporate Governance is required to be updated every 3 years.

The Board on 4 April 2024 reviewed and approved a full refresh of the Code of Corporate Governance. The next full refresh is due in 2027.

When required sectional updates are provided outwith the full refresh cycle.

2.3 Assessment

Throughout the CoCG the following amendment has been applied:-

- Director of HR, OD & OHS renamed to Director of People & Culture

Attached are revisions to the following sections:-

Section A – How business is organised. This section has now been refreshed and contains the revised Terms of Reference for:-

- Resources & Performance Committee
- Area Partnership Forum
- Remuneration Committee

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Once approved the Code of Corporate Governance will be available through the NHS Borders website under the Corporate Information section, as well as the Finance microsite on the intranet.

2.3.9 Route to the Meeting

This paper has been reviewed by the Audit and Risk Committee on 23 March 2026.

2.4 Recommendation

The Board asked to formally approve the sectional refresh of the Code of Corporate Governance.

The Board is asked to take **significant assurance** that the refreshed section of the Code of Corporate Governance is in line with appropriate legislative requirements and directions as issued by the Scottish Government.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Code of Corporate Governance Section A

SECTION A

How business is organised

1. THE BOARD AND ITS COMMITTEES (DIAGRAM)

2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGANISED

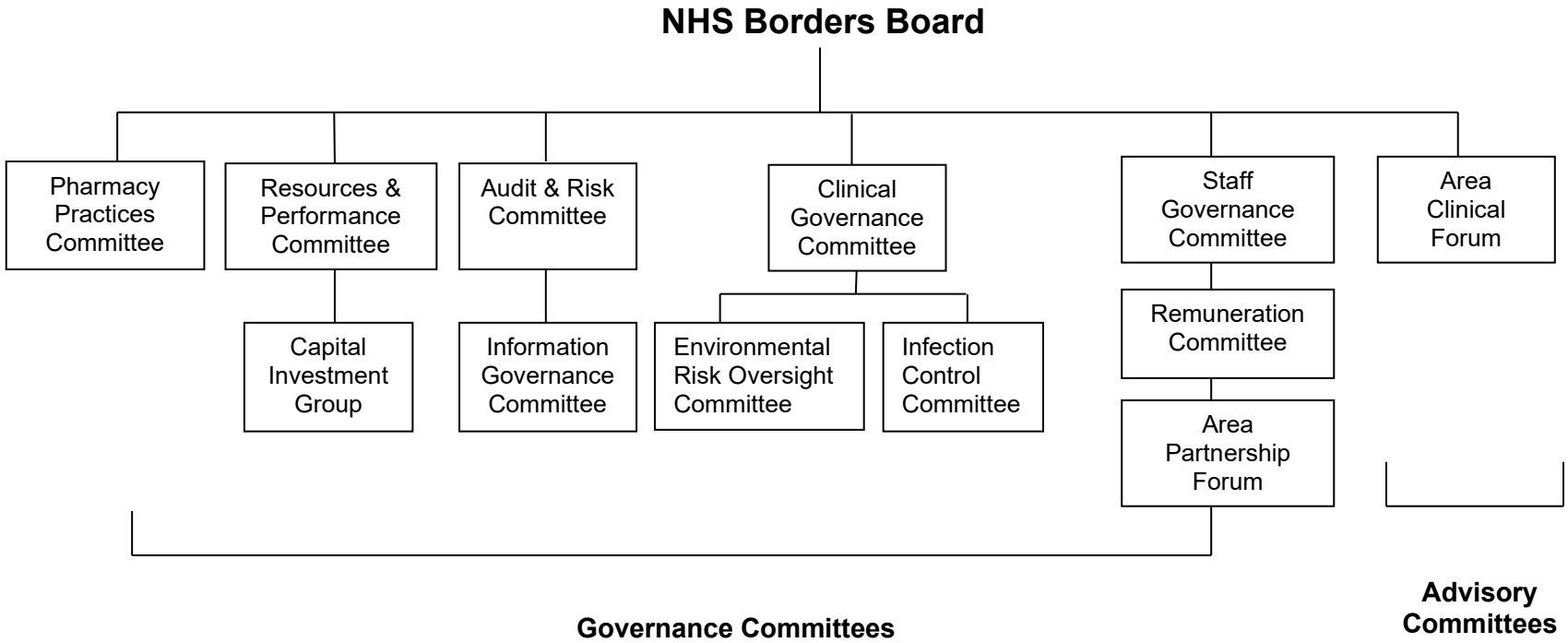
1. General
   Board Members – Ethical Conduct
2. Chair
3. Vice-Chair
4. Calling and Notice of Board Meetings
   - Deputations and Petitions
5. Conduct of Meetings
   - Authority of the Person Presiding at a Board Meeting
   - Quorum
   - Adjournment
   - Business of the Meeting
   - Board Meeting in Private Session
   - Minutes
6. Matters Reserved for the Board
7. Delegation of Authority by the Board
8. Execution of Documents
9. Committees
10. Guidance to exemptions under the Freedom of Information (Scotland) Act 2002
11. Records management

3. STANDING COMMITTEES

1. Establishing Committees
2. Membership
3. Functioning
4. Minutes
5. Frequency
6. Delegation
7. Committees
8. Purpose and Remits
   A. Resources and Performance Committee
   B. Capital Investment Group (sub-committee of Resources & Performance Committee)
   C. Audit & Risk Committee
   D. Information Governance Committee (sub-committee of Audit & Risk Committee)
   E. Clinical Governance Committee
   F. Infection Control Committee (sub-committee of Clinical Governance Committee)
   G. Environmental Risk Oversight Committee (sub-committee of Clinical Governance Committee)
   H. Area Drugs and Therapeutics Committee
   I. Staff Governance Committee
   J. Remuneration Committee (sub-committee of Staff Governance Committee)
   K. Area Clinical Forum
   L. Area Partnership Forum
   M. Pharmacy Practices Committee

Section A - Appendix 1: The Heath Boards (Membership and Procedure) (Scotland) Regulations 2001

1. THE BOARD AND ITS COMMITTEES



* The Pharmacy Practices Committee has delegated authority from the Board to meet when there are applications to consider in line with Statutory Instrument 1995 NO 414 (S28)
The National Health (Pharmaceutical Services) Service (Scotland) - Regulations 1995

2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGANISED

This section regulates how the meetings and proceedings of the Board and its Committees will be conducted and are referred to as 'Standing Orders'. The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 confirms the matters to be included in the Standing Orders. This is attached for reference at Appendix 1 of this section. The following is NHS Borders' practical application of these Regulations.

STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF BORDERS NHS BOARD

1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of Borders NHS Board, the common name for Borders Health Board, and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

Healthcare Improvement Scotland and NHS National Services Scotland are constituted under a different legal basis and are not subject to the above regulations. Consequently those bodies will have different Standing Orders.

The NHS Scotland Blueprint for Good Governance (issued through DL 2019) 02) has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the executive to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development)

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations and any request to co-opt member(s) to the Board. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified from taking part in any business of the Board in specified circumstances.

1.3 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting

of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.

1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of the Borders NHS Board. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however he or she may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations, or cross-refer to where the information is published.

1.11 The Board Secretary shall provide a copy of these Standing Orders to all members

of the Board on appointment. A copy shall also be held on the Board's website.

2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3 Vice-Chair

3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. The non-executive member of the Board with the whistleblowing portfolio is excluded from being Vice-Chair. A member who is an employee of the Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Chief Executive or Board Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason) the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the interim chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least five times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business, however this can only be for business which the Board is being informed of for awareness, rather than being asked to make a decision. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be

considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member at which meeting the item will be discussed. If any member has a specific legal duty or responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point.

4.7 With regard to calculating clear days for the purpose of notice under 4.6 and 4.9, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Additionally only working days (Monday to Friday) are to be used when calculating clear days; weekend days and public holidays should be excluded.

Example: If a Board is meeting on a Wednesday, the notice and papers for the meeting should be distributed to members no later than the preceding Thursday. The three clear days would be Friday, Monday and Tuesday. If the Monday was a public holiday, then the notice and papers should be distributed no later than the preceding Wednesday.

4.8 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.9 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held. The notice and the meeting papers shall also be placed on the Board's website. The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

Deputations and petitions

4.10 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken.

4.11 Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has concluded their presentation. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

4.12 Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of the Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts himself/herself inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees

will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member's, or an associate of their's, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of integration joint boards. The effect is that those members do not need to declare as an interest that they are a member of an integration joint board when taking part in discussions of general health & social care issues. However members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the Board, may be

adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2.

Decision-Making

5.15 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.16 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.17 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.18 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.

5.19 Where the Chair concludes that there is not a consensus on the Board's position on the item and/or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.20 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.21 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

5.22 The Board may agree to meet in private in order to consider certain items of business. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.23 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.24 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.25 The Board Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute which will be held electronically.

6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Delivery Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Delivery Plan, the Board should receive it at a public Board meeting.)

f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: This must be considered in private by the Board. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The Audit and Risk committee should advise the Board on the appointment, and the Board may delegate to the Audit and Risk committee oversight of the process which leads to a recommendation for appointment.)

Within the above the Board may delegate some decision making to one or more executive Board members.

6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the integration schemes for a local authority area.

6.4 The Board itself may resolve that other items of business be presented to it for approval.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions (Section G) and the Scheme of Delegation (Section F).

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Execution of Documents

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish. (https://learn.nes.nhs.scot/17367/board-development)

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required and shall review the terms within 2 years of their approval if there has not been a review.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed.

9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members include some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally, Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However, if the committee elects to consider certain items as restricted

business, then the meeting papers for those items will normally only be provided to members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time and shall call a meeting when requested to do so by the Board.

9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Borders NHS Board and is not to be counted when determining the committee's quorum.

10. Freedom of Information (Scotland) Act 2002

10.1 The Freedom of Information (Scotland) Act 2002 (FOI(S)A) was introduced by the Scottish Parliament to ensure that people have the right to access information held by Scottish public authorities. The Act states that any person can receive information that they request from a public authority, subject to certain exemptions such as protection of personal data and commercial interests, or national security. It came into force on 1 January 2005 and is retrospective, so that it includes all records held by the Board prior to 2005 as well as since that date.

10.2 Under FOI(S)A NHS Borders is required to:

- Provide applicants with help and assistance in finding the information they require within a given timescale;
- Maintain a publication scheme of information to be routinely published;
- Put in processes for responding to enquiries and undertaking appeals against decisions to withhold information.

10.3 Information as defined under FOI(S)A includes copies or extracts, including drafts, of any documents such as:

- reports and planning documents;
- committee minutes and notes;
- correspondence including e-mails;
- statistical information.

10.4 The FOI(S)A provides a range of exemptions which may be applied allowing the public authority to withhold information. Exemptions must be considered on a case by case basis and may be applied to all or only part of the information requested.

10.5 All documents will be scrutinised for information which may be withheld under an exemption to the Act prior to release.

10.6 Full details of the FOI(S)A exemptions and how to apply them can be found in the Freedom of Information (Scotland) Act 2002 which is available on the NHS Borders intranet Information Governance site at

http://intranet/new_intranet/microsites/index.asp?siteid=41&uid=2

10.7 Briefings on how to apply exemptions can be found on the Scottish Information Commissioners website at http://www.itspublicknowledge.info/ScottishPublicAuthorities/ScottishPublicAuthorities.asp.

10.8 For further advice on the Freedom of Information (Scotland) Act 2002, processes and application contact the Freedom of Information Officer or Communications Team.

11. Records management

11.1 Under the Freedom of Information (Scotland) Act 2002, NHS Borders must have comprehensive records management systems and process in place which must give clear guidance on time limits for the retention of records and documents.

11.2 Separate guidance has been produced for records management. The NHS Borders Records Management Policy can be found on the NHS Borders Intranet Information Governance site at http://intranet/new_intranet/microsites/index.asp?siteid=41&uid=2

3. STANDING COMMITTEES

1. Establishing Committees

1.1 The Board on the recommendation of the Chair shall create such Committees, as are required by statute, guidance, regulation and Ministerial direction and as are necessary for the economical efficient and effective governance of the Boards' business.

1.2 The Board shall delegate to such Committees those matters they consider appropriate. The matters delegated shall be set out in the Purpose and Remits of those Committees detailed in Paragraph 8, Purpose and Remits

1.3 The Chair may vary the number, constitution and functions of Committees at any meeting by specifying the proposed variation.

2. Membership

2.1 The Board on the recommendation of the Chair shall appoint the membership of Committees on an annual basis. By virtue of their appointment the Chair of the Board is an ex officio member of all Committees except the Audit & Risk Committee.

2.2 The Board on the recommendation of the Chair shall appoint the Chairs of the Governance Committees of NHS Borders Board.

2.3 Any Committee, shall include at least one Non-Executive Member of the Board, and may include persons, who are co-opted, and may consist wholly or partly of Members of the Board.

2.4 In recommending to the Board the membership of Committees, the Chair shall have due regard to the Committee purpose, role and remit, and accountability requirements as well as the skills and experience of individual Non Executives and any requirements associated with their recruitment. Certain members may not be appointed to serve on a particular Committee as a consequence of their positions. Specific exclusions are:

- Audit & Risk Committee - Chair of the Board together with any Executive Member or Officer.
- Remuneration Committee - any Executive Member or Officer.

2.5 The Board on the recommendation of the Chair has the power to vary the membership of Committees at any time, provided that this is not contrary to statute, regulation or direction by Scottish Ministers and is in accordance with the paragraph 2.4 above.

2.6 The Board on the recommendation of the Chair shall appoint Vice-Chairs of Committees. In the case of Members of the Board, this shall be dependent upon their continuing membership of the Board.

2.7 The persons appointed as Chairs of Committees shall usually be Non-Executive Members of the Board and only in exceptional circumstances shall the Chair recommend to the Board the appointment of a Chair of a Committee who is not a Non-Executive Member, such circumstances are to be recorded in the Minutes of the Board meeting approving the appointment.

2.8 Casual vacancies occurring in any Committee shall be filled as soon as may be practical by the Chair after the vacancy takes place.

3. Functioning

3.1 An Executive member or another specified Lead Officer shall be appointed to support the functioning of each Committee.

3.2 Committees may seek the approval of the Chair to appoint Sub-Committees for such purposes as may be necessary.

3.3 Committees may from time to time establish working groups for such purposes as may be necessary.

3.4 Where the functions of the Board are being carried out by Committees, the membership, including those co-opted members who are not members of the Board, are deemed to be acting on behalf of the Board.

3.5 During intervals between meetings of the Board or its Committees, the Chair of the Board or the Chair of a Committee or in their absence, the Vice Chair shall, in conjunction with the Chief Executive and the Lead Officer concerned, have powers to deal with matters of urgency which fall within the terms of reference of the Committee and require a decision which would normally be taken by the Committee. All decisions so taken should be reported to the next full meeting of the relevant Committee. It shall be for the Chair of the Committee, in consultation with the Chief Executive and Lead Officer concerned, to determine whether a matter is urgent in terms of this Standing Order.

4. Minutes

4.1 The approved Minute of each Committee of the Board shall be submitted as soon as is practicable to an ordinary meeting of the Board for information, and for the consideration of any recommendations having been made by the Committee concerned.

4.2 The Minute of each Committee meeting shall also be submitted to the next meeting of the Committee for approval as a correct record.

4.3 Minutes of the proceedings at a meeting of a Special Committee shall be made but these proceedings may be reported to the Board or to any Committee of the Board either by the Minutes or in a report from the Special Committee as may be considered appropriate.

5. Frequency

5.1 The Committees of the Board shall meet no fewer than four times a year.

6. Delegation

6.1 Each Committee shall have delegated authority to determine any matter within its purpose and remit, with the exception of any specific restrictions contained in Section F, Section 1 (Reservation of powers and delegation of authority – Matters reserved for Board agreement only).

6.2 Committees shall conduct their business within their purpose and remit, and in exercising their authority, shall do so in accordance with the following provisions. However, in relation to any matter either not specifically referred to in the purpose and remit, or in these Standing Orders, it shall be competent for the Committee, whose remit the matter most closely resembles, to consider such matter and to make any appropriate recommendations to the Board.

6.3 Committees must conduct all business in accordance with NHS Borders policies and the Code of Corporate Governance.

6.4 The Chair may deal with any matter falling within the purpose and remit of any Committee without the requirement of receiving a report of or Minute of that Committee referring to that matter.

6.5 The Chair may at any time, vary, add to, restrict or recall any reference or delegation to any Committee. Specific direction by the Chair in relation to the remit of a Committee shall take precedence over the terms of any provision in the purpose and remit.

6.6 If a matter is of common or joint interest to a number of Committees, and is a delegated matter, no action shall be taken until all Committees have considered the matter.

6.7 In the event of a disagreement between Committees in respect of any such proposal or recommendation, which falls within the delegated authority of one Committee, the decision of that Committee shall prevail. If the matter is referred but not delegated to any Committee, a report summarising the views of the various Committees shall be prepared by the appropriate officer and shall appear as an item of business on the agenda of the next convenient meeting of the Board.

7. Committees

- Resources and Performance Committee
  - Capital Investment Group (sub-committee of Resources & Performance Committee)
- Audit & Risk Committee
  - Information Governance Committee (sub-committee of Audit & Risk Committee)
- Clinical Governance Committee

    - Infection Control Committee (sub-committee of Clinical Governance Committee)
    - Environmental Risk Oversight Committee (sub-committee of Clinical Governance Committee)
- Staff Governance Committee
    - Remuneration Committee (sub-committee of Staff Governance Committee)
- Area Clinical Forum
- Area Partnership Forum
- Pharmacy Practices Committee

8. Purpose and Remits

A) RESOURCES AND PERFORMANCE COMMITTEE

1.1 Purpose

The Resources and Performance Committee (R&PC) is established in accordance with NHS Borders Board Standing Orders and Scheme of Delegation.

The Resources and Performance Committee is a Standing Committee of the NHS Board.

The overall purpose of the Resources and Performance Committee is to provide assurance across the healthcare system regarding resources and performance, ensure alignment across whole system planning and commissioning, and to discharge the delegated responsibility from the NHS Board in respect of asset management.

The Committee will receive reports, and draft plans for review and response in respect of; Finance, Performance, Capital, Asset Management, national and regional planning groups and the Health and Social Care Partnership strategic plan.

The Committee will oversee the development of a Financial Strategy for approval by the Board that is consistent with the principle of Patient Safety as our number one priority, but with reference to all other national and local priorities.

The Committee will act as the Performance Management Committee of the Board, the Service Redesign Committee of the Board and influence the early development of the strategic direction of the Board.

The scope of resource will include finance, workforce, property and technology.

1.2 Composition

Membership of the Committee shall be:

- Chair of the Board
- All Non Executive Directors
- Chief Executive
- Director of Public Health
- Medical Director
- Director of Nursing, Midwifery & AHPs
- Director of Acute Services
- Director of Urgent Care, Community Services & Mental Health
- Director of Quality & Improvement
- Director of Finance
- Director of People & Culture
- Director of Planning & Performance
- Chief Officer Health & Social Care Integration (accountable for the performance of the partnership and the delivery of the delegated services).
- Partnership Representative

Attendees shall be:

- Board Secretary (Secretariat)

Attendees may be invited to the Committee at the discretion of the Chair and it is anticipated, depending on the issues to be discussed, that other key individuals from the wider organisation will be asked to attend.

The Chair of the Resources and Performance Committee shall be a Non Executive.

The Lead Officer for the Resources and Performance Committee shall be the Chief Executive.

1.3 Meetings

Meetings of the Resources and Performance Committee will be quorate when one third of the whole number of members, of which at least two are Non Executive Members are present.

The Committee will be chaired by a Non Executive of the Board.

The Committee will meet no less than 4 times per year and conduct its proceedings in compliance with the Standing Orders of the Board.

The Chair of the Committee, in conjunction with the Chief Executive shall set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under Any Other Business or through the Committee Chair.

The agenda and supporting papers will be sent out by the Board Secretary, at least seven days in advance of the meetings to allow time for members' due consideration of issues.

Formal minutes and an action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out. The Committee will be supported by the Board Secretary who will submit the minutes for approval at the next Resources and Performance Committee meeting, prior to submission to the Board.

To avoid the Committee's agenda becoming over-burdened and unmanageable specific pieces of work may be delegated to the appropriate Director, sub group or short-life task and finish groups reporting to the Committee with very specific remits, objectives, timescales and membership.

1.4 Remit

The remit of the Resources and Performance Committee is to scrutinise the following key areas and provide assurance to the Board regarding:

- Whole system strategic planning including oversight of the healthcare services delegated to the IJB;
- Whole system financial planning, including an overview of budgets delegated;
- Compliance with statutory financial requirements and achievement of financial targets;

- Such financial monitoring and reporting arrangements as may be specified from time-to-time by Scottish Government Health & Social Care Directorates and/or the Board;
- The impact of planned future policies and known or foreseeable future developments on the underlying financial position of the Board;
- To review the development of the Board's Financial Strategy over a three year period and the Board's Annual Financial Plan making recommendations to the Board;
- The Property and Asset Management Strategy and Capital Plans of NHS Borders.
- The Board's performance against relevant targets and key performance indicators linked to the Scottish Outcomes framework.
- Whole system technology planning.
- Whole system workforce planning.

Appropriate governance in respect of risks, as allocated to the Committee by the NHS Board and/or Audit & Risk Committee relating to finance, planning, performance and property, reviewing risk identification, assessment and mitigation in line with the NHS Board's risk appetite and agreeing appropriate escalation.

1.5 Property and Asset Management

To ensure that the Property & Asset Management Strategy is in line with the Board's strategic direction and;

- that the Board's property and assets are developed, and maintained to meet the needs of 21st Century service models;
- that developments are supported by affordable and deliverable Business Cases with detailed project implementation plans with key milestones for timely delivery, on budget and to agreed standard;
- that the property portfolio of NHS Borders and key activities relating to property are appropriately progressed and managed within the relevant guidance and legislative framework, including assessment of backlog maintenance;
- that there is a robust approach to all major property and land issues and all acquisitions and disposals are in line with the Property Transaction Handbook (PTHB);
- to review the Capital Plan and submit to the NHS Board for approval and oversee the overall development of major schemes, including approval of capital investment business cases. The Committee will also monitor the implications of time slippage and / or cost overrun and will instruct and review the outcome of the post project evaluation;
- to review all Initial Agreements, Outline Business Cases and Full Business Cases and recommend to the NHS Board in line with the Scheme of Delegation.

To receive reports on relevant legislation and best practice including the Scottish Capital Investment Manual (SCIM), CEIs, audit reports and other Scottish Government Guidance.

1.6 Arrangements for Securing Best Value

The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for:

- The planning, appraisal, control, accountability and evaluation of the use of current and future resources.
- Reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with its statutory requirements.
- The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.7 Allocation and Use of Resources

The Committee has key responsibility for:

- Reviewing the development of the Board's Financial Strategy in support of the Integration Joint Board Strategic Plan, Annual Delivery Plan and Regional Delivery Plans, and recommending approval to the Board.
- Reviewing and agreeing the level of budget to be provided to the IJB for the functions delegated and make recommendations to the Board.
- Reviewing the H&SCI Strategic Plan to ensure the outcomes can be delivered within the Board's revenue and capital plans.
- Reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board.
- Monitoring the use of resources available to the Board.
- Reviewing the Property Strategy (including the acquisition and disposal of property) and make recommendations to the Board.

Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment); the review of the Property Strategy (including the acquisition and disposal of property); the review of all business cases coming forward for recommendation to the Board; and for making recommendations to the Board as appropriate on any issue within its terms of reference.

1.8 Strategy Development

The Committee will review the development of the NHS Board's Strategic Plan, ensuring that strategic planning objectives are aligned with the NHS Board's overall strategic vision, aims and objectives.

The Committee will scrutinise the development of all strategies which require approval by the Board, including the Annual Delivery Plan.

The Committee will ensure that strategies are compliant with the duties of the Board in respect of meeting legislative and good practice requirements.

The Committee will also ensure that there is an integrated approach to planning ensuring that workforce, finance and service planning are linked.

The Committee will ensure appropriate inclusion of National and Regional Planning requirements and monitor overall progress with the East of Scotland planning agenda.

The Committee will ensure NHS Borders input, at an appropriate level, to the draft IJB Strategic Plan, and promote consistency and coherence across the system highlighting issues which may impact the delivery of NHS Board aims and objectives.

1.9 Service Redesign/Transformation

The Committee will provide appropriate oversight to significant service redesign including security for cases for change and to ensure this is progressed in a collaborative way working across health, social care and other organisations, with explicit links between service redesign, service improvement, workforce planning and the strategic priorities for NHS Scotland.

The Committee will review and scrutinise all business cases coming forward and recommend for approval by the Board as appropriate.

1.10 Performance Management

The Committee will review the NHS Board Performance Management Framework ensuring it is in line with the National Performance Framework and make recommendations to the NHS Board.

The Committee will review the NHS Board's overall performance and planning objectives, and ensure mechanisms are in place to promote best value, improved efficiency and effectiveness and decision making across the healthcare system

The Committee may, from time to time, review individual services in relation to performance management, ensuring that health care is delivered to an efficient and cost-effective level.

The Committee will seek assurance on a rigorous and systematic approach to performance monitoring and reporting across the whole healthcare system to enable more strategic and better informed discussions to take place at the NHS Board.

The Committee will seek assurance as to the adoption of a risk based approach to performance management through routine review. This will focus on areas of corporate concern identified as requiring an additional strategic and collective approach to ensure delivery against whole system performance targets.

The Committee will maintain oversight of progress with the implementation of the financial improvement programme, receive reports, receive assurance on effective engagement, and provide support and advice.

1.11 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and is authorised to seek any information it requires from any employee. All Members, employees and agents of the Board are directed to co-operate with any request made by the Committee.

In order to fulfil its remit the Resources and Performance Committee may obtain whatever professional advice it requires, and require other individuals to attend meetings as required.

1.12 Reporting Arrangements

The Resources and Performance Committee reports to the Board.

The minutes of the Resources and Performance Committee meetings will be submitted to the next meeting of the Resources and Performance Committee for approval.

The minutes will then be presented to the following Ordinary Meetings of the Board for noting.

1.13 Review

The Terms of Reference of the Resources and Performance Committee will be reviewed on an annual basis.

The Resources & Performance Committee shall undertake an annual self assessment of the Committee's work.

B) CAPITAL INVESTMENT GROUP

1.1 Purpose

The group is established in order to provide a vehicle for management to address the requirements of the Board and its Committees with respect to the development of infrastructure strategy and related capital investment.

The NHS Borders Capital Investment Group (BCIG) will be responsible for the development and management of the Board's Property and Asset Management Strategy (PAMS) and associated capital plan, including prioritisation of resources available to the plan, and the monitoring of progress against same. The group will also undertake review and approval of capital business cases in line with the revised governance framework (to be developed).

The group will be responsible for ensuring that there are appropriate governance arrangements in place in relation to property and asset management, including compliance with the mandatory requirements of 'A policy for property and asset management in NHS Scotland', the Scottish Capital Investment Manual (SCIM), Scottish Public Finance Manual (SPFM) and the NHS Scotland Property Transactions Handbook (PTH).

1.2 Key Principles

In undertaking its business, the group will seek to meet the following functions:

- To provide **assurance** to the Board via the Resources& Performance Committee, on the strategic fit, appropriateness and value for money of capital investment, property and asset management proposals presented to it.

- To provide **accountability** by fulfilling its role as a decision-making body of the Board in respect of matters delegated to BCIG under the Board's scheme of delegation, and in making recommendations to the Board in relation to capital investment, property and asset management.

- To provide an **advisory** role to the Board in relation to capital investment or disinvestment issues.

1.3 Membership

- Director of Finance (Chair)
- Director of Planning and Performance (Vice-Chair)
- Head of Estates
- Head of Estates Projects
- Head of IM&T, or deputy
- Head of Planning & Performance
- Deputy Director of Finance
- Head of Procurement
- Acute Services Representative
- Primary & Community Services Representative
- Mental Health & Learning Disabilities Representative
- Corporate Services Representative
- Partnership Representative
- Medical Director (or Representative)
- Finance Business Partners

It is the responsibility of members to nominate a deputy if they are unable to attend any meeting.

1.4 Decision Making

For matters of prioritisation or approval, the meeting must be quorate.

To be quorate each meeting will have a minimum of 1 Director and no less than a total of six members, which must include:

- A member, or nominated deputy, from each Clinical Board (Acute services, PACS, Mental Health/LD) and from Corporate Services
- Head of Estates or Head of Estates Projects
- A Finance representative (if Director of Finance not present)
- A Planning & Performance representative (if Director of Planning & Performance not present)
- Head of IM&T (if Director of Planning & Performance not present)

Decisions will be made by consensus. A veto may be exercised by agreement of both Chair and Vice-Chair.

The Group may invite others to attend a meeting for discussion of specific items. That person may take part in the discussion but will not have a vote.

It is the responsibility of the member to read all papers prior to the meeting to ensure the agenda is followed in a timely manner.

1.5 Frequency of Meetings

A full meeting will be undertaken quarterly in line with the preparation of the Board's annual plan and its quarterly review cycle. Meetings will be scheduled to align with the business cycle of the Resources & Performance Committee.

Additional meetings will be scheduled according to need during those months where there is no full meeting scheduled. Where no decisions are required attendance at these meetings will be determined on the basis of business need.

The agenda and papers will be issued at least seven working days in advance of the meeting.

1.6 Remit

The remit of the group is:

- To ensure that the Board's Property & Asset Management Strategy (PAMS) is prepared in line with the requirements of CEL 35 (2010), is aligned to the Board's clinical and other relevant strategies, and is subject to review on a regular basis.

- To ensure there are arrangements in place for the monitoring of property transactions and compliance with the NHS Scotland Property Transactions Handbook, including acquisition and disposal of assets by purchase, sale or lease.

- To provide challenge and scrutiny to the development of business cases in relation to the suitability, feasibility and acceptability of the plans described.

- To ensure that business cases are prepared in line with the requirements of the Scottish Capital Investment Manual (SCIM).

- To review and/or approve business cases for capital investment within the limits of delegated authority.

- To review proposed applications for funding, including external and charitable funding, in order to assess and make recommendations as appropriate.

- To make recommendation to the Board (and its Committees) in relation to the prioritisation of capital resources through the development of a five year capital plan.

- To make recommendation and/or approve the utilisation of in year slippage arising from the Board's capital plan.

- To ensure that arrangements are in place for the post-project evaluation of capital investments.

1.7 Reporting Arrangements

The NHS Borders Capital Investment Group will report to the Board's Resources & Performance Committee.

A Capital monitoring report will be prepared quarterly for review by the group prior to submission to the Resources & Performance Committee.

Specific pieces of work will be delegated to an appropriate officer or to short-life working groups, where appropriate.

1.8 Sub Groups

The group may constitute such sub-groups as required to meet the requirements of its workplan.

1.9 Review

Membership and frequency of the Group will be reviewed annually.

The NHS Borders Capital Investment Group shall undertake an annual self-assessment of the Committee's work.

C) AUDIT & RISK COMMITTEE

1.1 Purpose

To assist the Board in the delivery of its responsibilities for issues of risk, control and governance and associated assurance including the conduct of conduct of public business and the stewardship of funds under its control.

To provide assurance to the Board that:

- An appropriate system of internal control is in place;
- Business is conducted in accordance with the law and proper standards;
- Public money is safeguarded and properly accounted for;
- Governance arrangements are in place to cover the NHS functions which are delegated and the resources which are provided to the IJB are satisfactory, fully utilised, regularly reviewed and updated;
- Financial Statements are prepared timeously, and give a true and fair view of the financial position of the Board for the period in question;
- Affairs are managed to secure economic, efficient and effective use of resources;
- Reasonable steps are taken to prevent and detect fraud and other irregularities;
- Effective processes and systems of Risk Management are in place;
- Assurance from risk owners that review and mitigation is undertaken for very high risks;
- Effective systems of Information Governance are in place.

1.2 Membership

Non-Executive Members

4 core members from the non-executive members, excluding the following:

- Chair of the Board

Chair of the Committee

A core non-executive member of the Audit & Risk Committee shall be appointed as the Chair of the Committee by the Chair of the Board.

Ordinarily the Audit & Risk Committee Chair cannot be the Chair of any other Governance Committee of the Board. The Governance Committees are the Staff Governance Committee, Clinical Governance Committee, Information Governance and Public Governance Committee.

In Attendance

Executive Directors
- Chief Executive (as Accountable Officer)
- Director of Finance, Procurement, Estates and Facilities (as Chief Finance Officer)
- Director of Quality and Improvement (as Lead for Risk Management)
- Director of Acute Services

Other Attendees
- Chief Internal Auditor
- External Auditor
- Deputy Director of Finance – Head of Finance

Other officers of the board may be invited to the Committee at the discretion of the Chair.

The Lead Officer for the Audit & Risk Committee shall be the Director of Finance, Procurement and Estates and Facilities.

The Committee will be supported by a nominated PA.

1.3 Meetings

The Committee will meet at least four times a year. The Chair of the Committee may convene additional meetings as he/she deems necessary.

The Board or Accountable Officer may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

The Audit & Risk Committee Chair will have the power to exclude all others except members from a meeting.

The quorum for the Audit & Risk Committee shall be two non-executive members.

The Chair of the Committee, in conjunction with the Director of Finance as Lead Officer for the Committee, will set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under AOB ('Any Other Business') or through the Committee chair.

A workplan approved on an annual basis by the Committee will identify the key items of business to be discussed at each meeting.

The agenda and supporting papers will be sent out at least seven days in advance of the meetings to allow time for members' due consideration of issues.

Formal minutes and an action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out. The minutes will be submitted for approval at the next Audit & Risk Committee meeting, prior to submission to the Board.

The Chief Internal Auditor and the representative of the appointed external auditors shall have free and confidential access to the Chair of the Audit & Risk Committee.

1.4 Remit

The main objectives of the Audit & Risk Committee are to ensure compliance with NHS Borders's Code of Corporate Governance and to seek assurance on the effectiveness of the Board's systems of governance, internal control and risk management.

The duties of the Audit & Risk Committee are in accordance with the Scottish Government Audit Committee Handbook and are as detailed below.

Internal Control and Corporate Governance

To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment (including financial and non-financial controls);
- Information Governance and communication;
- Risk Management;
- Control procedures;
- Decision making processes;
- Monitoring and corrective action;
- Annual review of the Governance Framework and the Governance Statement (as included within the Board's Annual Report and Accounts), including review of assurance statements from Executive directors and Board Committees.

To review the system of internal financial control, including:

- Safeguarding of assets against unauthorised use and disposition;
- Maintaining proper accounting records and the reliability of financial information used within the organisation or for publication;
- Ensuring that the Board's activities are within the law, regulations, Ministerial Direction and the Board's Code of Corporate Governance;
- Presenting an annual Statement of Assurance on the above to the Board, in support of the Governance Statement by the Chief Executive.

Risk Management

To evaluate the effectiveness of risk management arrangements on an annual basis (except where otherwise noted) and to agree the level of assurance taken in relation to:

- Risk Management Strategy*
- Risk Management and Adverse Event Management Policies*
- Risk Appetite of the Board
- Board Assurance Framework
- Strategic risk horizon scanning
- Systems and processes in place for the management of strategic and operational risk, including Key Performance Indicators

**reviewed on a three year basis*

Internal Audit

- Make recommendation to the Board for the appointment of its Chief Internal Auditor and Internal Audit service following appropriate procurement;
- Review and approve the arrangements for delivery of Internal Audit;
- Review and approve the Internal Audit Strategic and Annual Plan;
- Review all Internal Audit reports and disseminate to the relevant Board Committees in line with the Internal Audit Protocol;
- Ensure that executive leads are held accountable for the delivery of actions arising from audit recommendations within agreed timescales; review any actions where completion date falls due outwith the financial year within which the report has been prepared;
- Consideration of the Chief Internal Auditor's Annual Report and Assurance Statement;
- Review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures;
- Ensure that there is direct contact between the Audit Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors;
- Collaboratively work with the other partner bodies in support of the functions delegated to the IJB.

External Audit

- Note the appointment and remuneration of the External Auditors and to examine any reason for the resignation or dismissal of the Auditors;
- Review the annual Audit Plan including the Performance Audit programme;
- Consideration of all statutory audit material for the Board, in particular:
    - Audit reports (including Performance Audit studies)
    - Annual Report
    - Chief Executive Letters
- Monitor management action taken in response to all External Audit recommendations, including VFM studies;

- Review of matters relating to the Certification of the Board's Annual Report and Accounts (Exchequer Funds), Annual Patients' Private Funds Accounts, Annual Endowment Funds Accounts and the Annual IJB Accounts;
- Meet with the External Auditors at least once per year and as required, without the presence of the Executive Directors;
- Review the extent of co-operation between External and Internal Audit;
- Annually appraise the performance of the External Auditors;
- Review the terms of reference, appointment and remuneration of external auditors for the Board Endowment Funds and Patient Funds Accounts.

Code of Corporate Governance

- Review the Code of Corporate Governance which includes Standing Orders, Schemes of Reservation and Delegation, Standing Financial Instructions and recommend amendments to the Board;
- Examine the circumstances associated with each occasion when Standing Orders have been waived or suspended;
- Review and assess the operation of any Schemes of Delegation;
- Monitor compliance with the Members' Code of Conduct.

Annual Report and Accounts

- Undertake scrutiny of the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- Review and recommend for approval the Health Board Consolidated Annual Report & Accounts;
- Review the Annual Accounts for the NHS Borders Endowment Funds;
- Review and recommend for approval the Annual Accounts for Patients' Funds;
- Review schedules of losses and compensation payments.

Other Matters
The Committee shall:

- Review the arrangements that the Board has in place for the prevention and detection of fraud, and will receive regular reports on the business activities progressed by the Board's local Countering Fraud Operational Group;
- Monitor how the Board addresses risk in relation to potential litigation;
- Review the effectiveness of arrangements in place for the development, implementation and monitoring of directions issued by the Scottish Borders Integration Joint Board;
- Promote the use of audit reports as improvement tools by ensuring that they are directed for the attention of appropriate individuals or groups;
- Review and report on any other matter referred to the Committee by the Board;
- Review its own performance and effectiveness, including its running costs and terms of reference on an annual basis;
- Keep up to date by having a mechanism to ensure topical legal and regulatory requirements are brought to Members' attention;
- Review any arrangements in place for special investigations, where these arise.

1.5 Best value

The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.6 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, may seek any information it requires from any employee. All Members, employees and agents of the Board are directed to co-operate with any request made by the Committee. The Committee is required to review its Terms of Reference on an annual basis.

The Committee is authorised by the Board to obtain independent professional advice and to secure attendance of others with relevant experience and expertise if it considers it necessary.

1.7 Reporting Arrangements

- The Audit & Risk Committee reports to the Board.
- Following a meeting of the Audit & Risk Committee, the minutes of that meeting should be approved at the next Committee meeting and then presented at the following Board meeting.
- The Audit & Risk Committee should annually, and within three months of the start of the financial year, approve a work plan detailing the work to be taken forward by the Audit & Risk Committee.
- The Audit & Risk Committee will produce an Annual Assurance Statement which describes the outcomes of work undertaken by the Committee during the year in order to provide assurance to the Board that the Committee has met its remit. This statement must be presented to the Board meeting considering the Annual Accounts.

1.8 Review

The Terms of Reference of the Audit & Risk Committee will be reviewed on an annual basis.

D) INFORMATION GOVERNANCE COMMITTEE

1.1 Introduction

NHS Borders hereby resolves to establish a committee to be known as the Information Governance Committee (the Committee).

1.2 Role

To provide assurance to NHS Borders Audit & Risk Committee that the Board is compliant with legislation relating to information governance, and that robust delivery systems and processes are in place to support this.

1.3 Membership

Committee membership

- Medical Director, Chair
- Caldicott Guardian, Vice chair
- Senior Information Risk Officer [SIRO]
- Chief Clinical Information Officer (CCIO)
- Acute Services representative
- Primary & Community Services representative
- Mental Health & Learning Disability representative
- General Practitioner
- Area Partnership Forum representative
- Finance representative
- Head of IM&T
- Director of Quality and Improvement
- Information Governance & Cyber Assurance Manager

In attendance

- Information Governance Lead
- Data Protection Facilitator
- Freedom of Information Officer
- Cyber Security Manager
- Committee Administrator

Meetings will not be quorate and no business will be transacted if less than 50% of the members or their representatives are present. Members are to nominate a deputy if they are unable to attend.

Others will also be invited to attend as the Committee sees fit.

1.4 Frequency

Meetings shall be held not less than 4 times per annum.

In the event of a planned meeting not being quorate, the recommendations of those who attended will be circulated within 7 days of the meeting for agreement by the majority of the Committee.

The Chair may convene a meeting of the Committee at any time, or when requested by the Audit Committee, and has the authority to exclude all others except members from a meeting.

If an event of significance to the Committee arises between meetings, the Director of Planning & Performance (as executive lead for Information Governance), or their nominated deputy, will bring this to the attention of the chair of the Committee.

The agenda and supporting papers will be sent to members at least 5 working days before the date of the meeting.

Any additional papers can be circulated via email.

1.5 Authority

The Committee is authorised by the Audit Committee to investigate any activity within its Terms of Reference. It is also authorised to seek any information it requires from any member, employee or agent of NHS Borders. All members, employees and agents of NHS Borders are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Audit Committee to obtain outside legal or other independent professional advice and to secure the attendance of others with relevant experience and expertise if it considers this necessary.

1.6 Scope

The Information Governance Committee to provide assurance to NHS Borders Audit Committee that the Board is compliant with legislation relating to information governance, and that robust delivery systems and processes are in place to support this.

The duties of the committee are to:

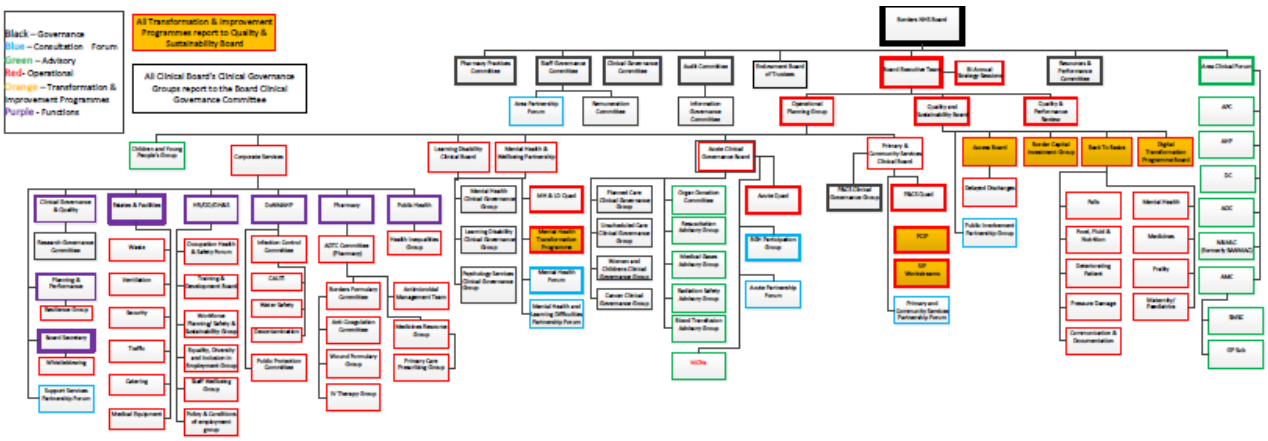
- Ensure that appropriate structures and systems are in place to support and deliver Information governance.
- Assure NHS Borders Audit Committee that these structures are operating effectively
- Ensure NHS Borders complies with UK and Scottish legislation in respect to Information Governance.
- Assist in the development and review of Information Governance policies
- Approve Policies and supporting guidelines as required
- Provide a vehicle for dissemination of Information Governance information with the aim of applying continuity and consistency across NHS Borders.
- Highlight to the Clinical Executive-Operational Group identified trends and developments in Information Governance that may affect the workforce, patients and others.
- Ensure NHS Borders complies with NHS Scotland Information Governance and policies and procedures
- Promote best practice throughout NHS Borders in all Information Governance matters.
- Provide regular reports to NHS Borders Audit Committee by submission of the approved minutes, and report any specific significant problems as they emerge.

These duties will be discharged through a standing agenda, which will include reporting on the following key activities:

- Caldicott / Confidentiality
- Data Protection
- Education, training and staff awareness on Information Governance
- Freedom of Information
- Incident review and monitoring
- IT Security and Cyber Security
- Records Management

These key activities will be amended as required and formally reviewed annually.

Reporting Arrangements



The committee is operationally accountable to the Clinical Executive with scrutiny and assurance resting with the Board's Audit Committee.

Minutes will be kept of the proceedings of the Committee. The draft minutes are to be circulated, within ten working days to the Chair of the Committee, and within five working days thereafter to members.

The Chair of Committee shall provide assurance on the work of the Committee and the approved minutes will be submitted to the Operational Planning Group meeting for information.

The Committee will conduct an annual review of its role and function

Appendix 1

Definitions

Information Governance means handling information in a confidential and secure manner to appropriate ethical and quality standards. Information Governance is a key issue for all NHS organisations and is fundamental to the effective delivery of health services, particularly as we move towards an electronic health record.

IT Security protects the information and also the physical infrastructure that supports the information from theft or damage to the hardware, software or electronic data, as well as from disruption or misdirection of the services they provide. IT Security also covers the creation of policies and standards to ensure all information is protected.

Cyber Security is solely concerned with preventing electronic attacks against electronic data.

Key Business Areas / Legislative

- Data Protection Act 2018
- Networks and Information Systems Regulations 2018

- UK General Data Protection Regulation
- EU General Data Protection Regulation
- Freedom of Information (Scotland) Act 2002
- Confidentiality: NHS Scotland Code of Practice
- Public Records (Scotland) Act 2011 – Records Management
- Information Security Standards
- Caldicott Guardianship

E) CLINICAL GOVERNANCE COMMITTEE

1.1 Purpose

To provide the Board with the assurance that clinical governance controls are in place and effective across NHS Borders.

1.2 Composition

a) Membership

The Clinical Governance Committee is appointed by the Board and shall be composed of four Non-Executive Board members, one of whom shall be the Chair of the Area Clinical Forum. One of these members shall be appointed as Chair. Membership will be reviewed annually.

b) Appointment of Chair

The Chair and Vice Chair of the Committee shall be appointed by NHS Borders Board Chair.

c) Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The following NHS Board officers or their representatives will normally attend meetings.

- Director of Quality & Improvement
- Chief Executive
- Director of Acute Services
- Medical Director
- Director of Public Health
- Director of Nursing, Midwifery & Allied Health Professionals
- Director of Psychological Services
- Director of Pharmacy
- Associate Medical Directors
- Lead Nurse for Patient Safety and Care Assurance *Associate*
- Directors of Nursing
- Associate Director of Allied Health Professions
- Associate Director for Midwifery and General Manager for Women & Children Services
- Infection Control Manager
- Risk Manager

Others will also be invited to attend as the Committee sees fit.

All Board Members have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

1.3 Meetings

a) Frequency

The Clinical Governance Committee will meet six times a year to fulfil its remit.

b) Agenda and Papers

The Chair of the Committee, in conjunction with the nominated lead Executive and the Director of Quality & Improvement will set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under Any Other Business (AOB) or through the Committee Chair.

The agenda and supporting papers will be sent out by the Committee Administrator, seven days in advance of the meetings to allow time for members' due consideration of issues.

c) Quorum

Two members of the Committee, including the Chair, will constitute a quorum. If the Chair is not available, the Vice-Chair will chair the meeting. If neither the Chair nor Vice-Chair is available, the other members will decide who will chair the meeting.

d) Minutes

Formal minutes will be kept of the proceedings by the Committee Administrator and submitted for approval at the next Clinical Governance Committee meeting, prior to submission to the Board.

Recognising the issue of relative timing and scheduling of meetings, minutes of the Clinical Governance Committee may be presented in draft form to the next available Board meeting.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

e) Other

In order to fulfill its remit, the Clinical Governance Committee may, within current financial constraints, obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of board staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

1.4 Remit

The main duties of the Clinical Governance Committee are to receive assurances that clinical governance controls are in place and effective across NHS Borders, on behalf of NHS Borders Board; and that the principles of clinical governance are applied to the health improvement activities of the Board.

a) General

- assure the Board that appropriate structures are in place to undertake activities which underpin clinical governance;
- review the systems of clinical governance, monitoring that they operate effectively and that action is being taken to address any areas of concern;
- review the mechanisms which exist to engage effectively with healthcare partners and the public;
- encourage a continuous improvement in service quality;
- ensure that an appropriate approach is in place to deal with clinical risk management, including patient safety, across the NHS Borders system;
- review performance in management of clinical risk.
- monitor complaints response performance on behalf of the Board;
- promote positive complaints handling, advocacy and feedback including learning from adverse events;
- monitor the processes whereby infections are monitored and controlled;
- monitor mortality in and out of hospital with specific reference to unexpected or unusual deaths;
- receive reports on child and adult protection activities;
- produce an Annual Clinical Governance Report;
- ensure that appropriate action plans are developed, implemented and monitored as a result of published national reports and inquiries; and
- assure the Board that appropriate structures are in place to ensure robust links to the Healthcare Quality Strategy

b) Internal Monitoring

- review the Internal Clinical Governance annual audit priorities;
- make recommendations to the NHS Borders Audit Committee on the requirements for internal audit to support clinical activities;
- receive and consider Clinical Audit Reports along with regular Progress Reports;
- review the actions taken by the Chief Executive, Medical Director and Director of Nursing, Midwifery and Allied Health Professionals on any recommendations or issues arising from Audit Reports; and
- review the effectiveness of the Clinical Audit Programme.

c) External Monitoring

- review Audit Reports from external monitoring bodies in relation to clinical governance; and
- monitor and report to the Board that appropriate actions in relation to external review and monitoring of clinical governance are being taken.

1.5 Risk Reporting

The Committee shall receive reports from relevant service leads within the areas of its remit. As a result of these reports, and considering areas of interest to the Committee, any areas of risk shall be highlighted and reported.

An action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out.

1.6 Best Value

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis. The outcome of this review shall be included in the Annual Report.

1.7 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

1.8 Reporting Arrangements

The Clinical Governance Committee is a standing committee of the Board and is accountable to the Board and shall formally report to the Board through the Annual Report. Otherwise reporting shall be by exception reporting.

The Chair of the Committee shall submit an Annual Assurance Statement on the work of the Committee to the Board. The timing of this will align to the Board's consideration of the Chief Executive's Statement of Internal Control for the associated financial year.

The Clinical Governance Committee shall undertake an annual self assessment of the Committee's Work.

F) INFECTION CONTROL COMMITTEE

1.1 Purpose

This committee fulfils the requirements of the Scottish Government Health Directorates (SGHD), outlined in HDL (2001) 53 and HDL (2005) 8, for all NHS Boards to establish an Infection Control Committee.

The Infection Control Committee (ICC) exists to maintain an overview of infection control priorities across NHS Borders, and to link into the healthcare governance processes. It will ensure that infection control issues are managed and escalated appropriately.

1.2 Composition

The Committee includes appropriate representation from across NHS Borders as detailed below:-

Committee Member	Named Deputy	Quorum - Committee Requirements
Director of Nursing & Midwifery and AHPs (HAI Executive Lead) (Chair)	Associate Directors of Nursing (ADON) as nominated	Minimum of 1 Committee Member or Deputy
Medical Director	Associate Medical Directors or Clinical Director as nominated	Minimum of 1 Committee Member or Deputy
Consultant Microbiologist (ICD)	Not applicable	Minimum of 2 or more of the ICD, ICM or IPCN
Infection Control Manager (ICM)	Senior Infection Control Nurse	
Infection Prevention & Control Nurse (IPCN)	Not applicable	
Consultant in Public Health Medicine (CPHM)	Health Protection Nurse (HPN)	
BGH Representative (Associate Director of Nursing) (Deputy Chair)	General Manager, Clinical Service Manager or Clinical Nurse Manager	Minimum of 1 Committee Member or Deputy
Primary and Community Services Representative (Clinical Nurse Manager)	Primary and Community Services Representative (Clinical Nurse Manager)	Minimum of 1 Committee Member or Deputy
Mental Health and Learning Difficulties Representative (Operational Manager)	Mental Health Representative and Learning Difficulties (Operational Manager)	Minimum of 1 Committee Member or Deputy
Head of Estates	Estates Manager	
Head of Soft FM (Facilities)	Facilities Team Lead	
Head of Quality and Clinical Governance	Clinical Governance and Quality Facilitator	
Antimicrobial Pharmacist	Pharmacist as nominated	
Head of Occupational Health	Occupational Health Nurse Manager	
Head of Health and Safety	Safety Advisor	
Member of public	Not applicable	
Staff Side Representative	Staff Side Representative as nominated	

1.3 Meetings

Frequency of Meetings

The ICC meets every 6 weeks. Patient specific details will not be discussed. If there is a high level of interest from members of the public in joining the Committee, selection will be through an interview process.

Secretarial Support and Minutes

The Infection Control Administrator will provide admin support to the ICC.

At least seven days notice will be given of the agenda. Minutes will be ratified at each meeting and agreed and noted as a correct record by the Committee.

Members who are unable to attend will send a deputy as indicated under section 1.2. Membership will be reviewed at least annually.

Other staff representatives may be co-opted as necessary to attend either the full Committee meeting or support working sub-groups.

Quorum and Voting

Quorum of the Committee is as indicated under section 1.2.

Circulation of Minutes

Minutes of the meetings will be circulated to all members and will be submitted to the Clinical Governance Committee.

1.4 Remit

- Approves the national and local objectives and priorities for targeted surveillance of infection.
- Approves the annual Infection Control Workplan.
- Monitors the progress of the annual Infection Control Workplan
- Responsible for assessment of levels of compliance with National HAI Standards.
- Receives reports and monitors action plans following HEI inspections.
- Critically review infection control surveillance data and evidence of actions implemented to reduce the incidence of HAI
- Provide guidance and support in the development of actions specific to Infection Prevention & Control.
- Consider risks to be added to the risk register and monitor
- Monitors infection related incidents and oversees related actions
- Provide assurance to NHS Boards Board in relation to Infection Prevention & Control.
- Provides advice and support on the implementation of policies/ procedures /guidelines.
- Delegated authority to approve all infection control policies.
- Approves the annual infection control audit programme and monitors progress, actions and learning from audits.

- Co-operates and participates in the periodic audits undertaken by the Board's Internal Audit when relevant to provide assurance that an effective system of infection control is in place.
- Tasks the Infection Prevention & Control Team and Health Protection Team to investigate and manage outbreaks of infection. Reports will be presented to ICC following an outbreak incident.

Duties of membership:

Chair

- Nominate a deputy in their absence.
- Ensures all members have access to up-to-date legislation and guidance relevant to infection control.
- Escalate to the Clinical Governance Committee appropriate risks that have been identified together with actions being taken to minimise the level of risk.
- Formally write to Committee members and their line manager if they fail to attend 3 consecutive meetings.

Committee Members:

- Nominate deputy if unable to attend
- Provide advice and support to the Infection Control Team (ICT) and the Health Protection Team (HPT).
- Consider the impact on the organisation of legislation, HDL, Scottish Government directives, and other relevant standards and reports

1.5 Risk Reporting

The Committee will routinely review infection control risks and escalate as appropriate.

1.6 Best Value

Membership and frequency of the Committee meetings will be regularly reviewed.
Clear description of agenda items, and opportunity provided to public representatives to a pre-meeting briefing.

1.7 Authority

As detailed in the remit, the Committee monitors progress against the Infection Control Work Plan, provides assurance and escalates risks and issues, and approves Infection Control Policies.

1.8 Reporting Arrangements

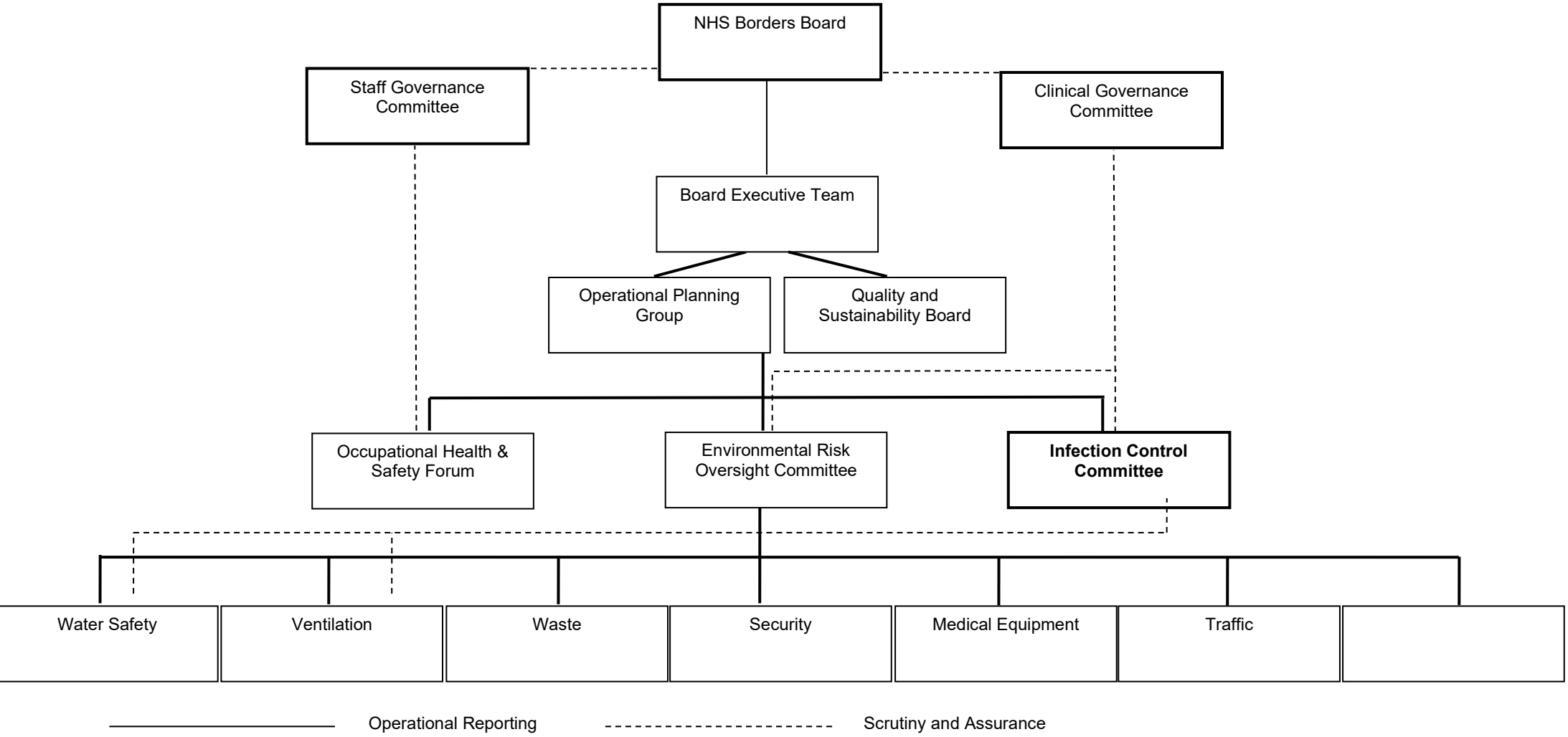
The ICC formally reports to the Operational Planning Group with a dotted line to the Clinical Governance Committee for scrutiny and assurance.

1.9 Accountability Arrangements

Refer to Appendix 1

Infection Control Committee – Reporting Structure

Appendix 1



G) ENVIRONMENTAL RISK OVERSIGHT COMMITTEE

1.5 Purpose

This Group fulfils the requirements of CEL35 (2010), the Scottish Health Technical Memorandums and Notes and Health and Safety Legislation. Statutory compliance relating to inspection, operations and management of assets.

The Environmental Risk Oversight Group (EROG) exists to maintain an overview of environmental risk priorities across NHS Borders, and to link into the healthcare governance processes. It will ensure that environmental risk issues are managed and escalated appropriately.

This group is constituted to provide specialist technical oversight to areas of risk relating to the built environment. It does not replace the existing risk management functions performed by other groups including: Infection Control Committee, Occupational Health & Safety Forum, Operational Planning Group (OPG).

1.6 Composition

The Group includes appropriate representation from across NHS Borders as detailed below:

Group Member	**Named Deputy**	**Quorum - Group Requirements**
Director of Finance	Director of Quality and Improvement	Minimum of 1 Group Member or Deputy
Director of Quality and Improvement	Director of Finance	
Consultant Microbiologist (ICD)	Not applicable	Minimum of 1 Group Member or Deputy
Infection Control Manager (ICM)	Senior Infection Control Nurse	
Head of Hard FM (Estates)	Estates Programme Manager	Minimum of 1 Group Member or Deputy
Estates Programme Manager	Head of Hard FM (Estates)	
Head of Soft FM (Facilities)	Not applicable	
Risk Manager	Not applicable	
Head of Health and Safety	Health and Safety Lead Advisor	Minimum of 1 Group Member or Deputy
Partnership Representative*	Not required	N/A

*Partnership attendance is optional. All risks under review will be considered through separate forums in line with risk management policy.

a) Frequency of Meetings

The EROC meets every 6 weeks.

b) Secretarial Support and Minutes

The BET administrative team will provide admin support to the EROC.

At least seven day's notice will be given of the agenda.

Members who are unable to attend will send a deputy as indicated under section 1.2. Membership will be reviewed at least annually.

Other staff representatives may be co-opted as necessary to attend either the full Group meeting or support working sub-groups.

c) Quorum and Voting

Quorum of the Group is as indicated under section 1.2.

d) Circulation of Minutes

Minutes of the meetings will be circulated to all members and will be submitted to the Clinical Governance Committee.

1.7 Remit

- Provide oversight of environmental risks outwith risk appetite to assess further actions needed and make recommendations to the organisation where further resources are required
- Monitor levels of compliance with statutory and other guidance and for maintaining a record of non-compliance and the mitigating actions
- Monitor risk around the built environment including considering, recording and recommending derogations to any standards
- Develop and maintain the Board policy for derogations
- Receives and considers escalation from sub-groups
- Receives reports and monitors action plans following inspections or internal/external audit
- Provide assurance to NHS Boards Board and sub-committees in relation to Environmental Risk.
- Monitor compliance with the annual statutory audit and compliance risk tool programme and monitors progress
- Co-operates and participates in the periodic audits undertaken by the Board's Internal Audit when relevant to provide assurance that an effective system of control is in place.

1.4 Duties of membership:

Chair

- Nominate a deputy in their absence.
- Ensures all members have access to up-to-date legislation and guidance relevant to Estates and Environmental Risk
- Escalate very high risks, as considered from the Board risk appetite approach to the Operational Planning Group
- Escalate to the Clinical Governance Committee appropriate risks that have been identified together with actions being taken to minimise the level of risk.

- Formally write to Group members and their line manager if they fail to attend 3 consecutive meetings.

Group Members:

- Nominate deputy if unable to attend
- Provide advice and support to the Estates and Facilities Teams
- Consider the impact on the organisation of legislation, HDL, Scottish Government directives, and other relevant standards and reports

1.10 Risk Reporting

The Group will routinely review environmental risks and escalate as appropriate.

1.11 Best Value

Membership and frequency of the Group meetings will be regularly reviewed.

1.12 Authority

As detailed in the remit, the Group monitors progress against the Estates Work Plan, provides assurance and escalates risks and issues.

1.13 Reporting Arrangements

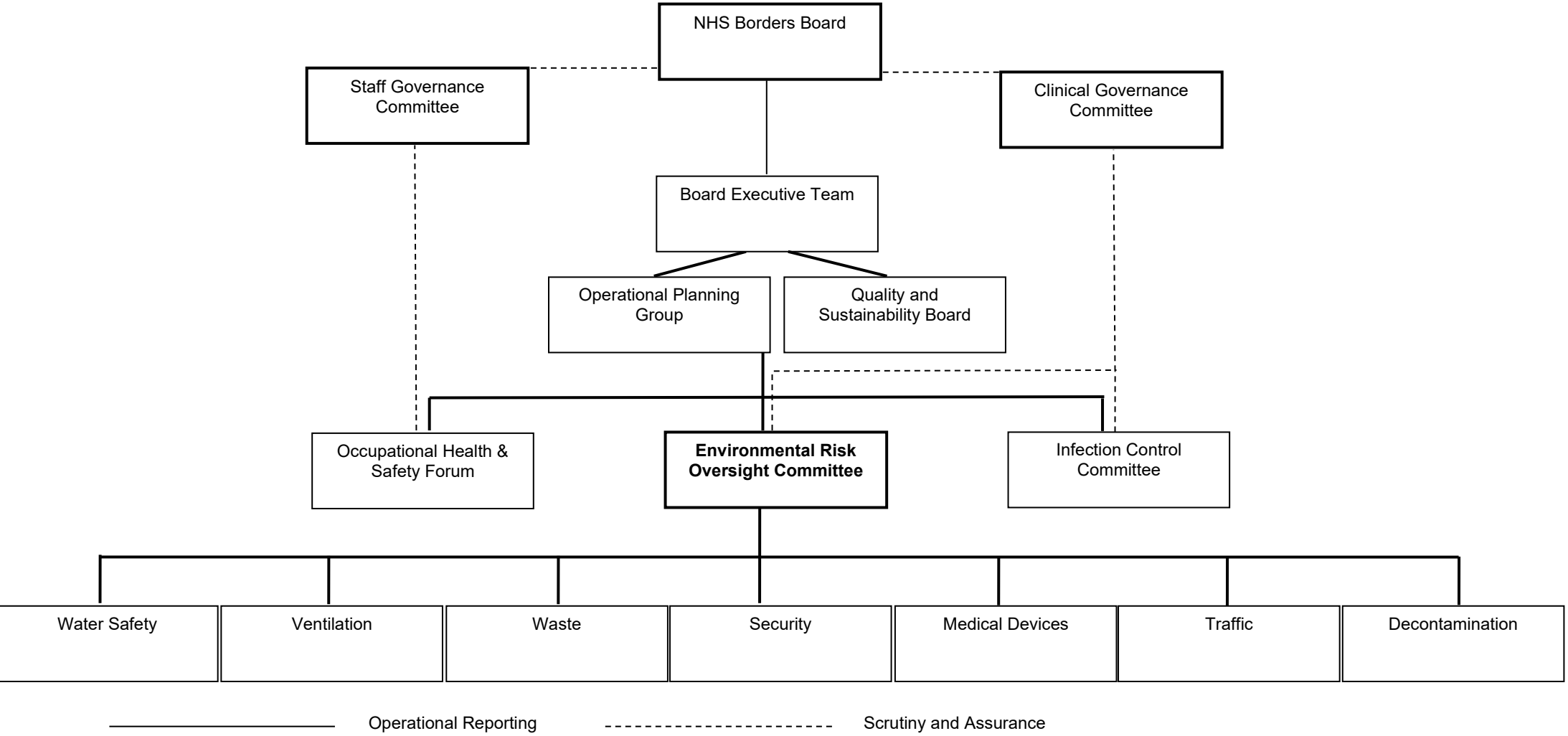
The EROC formally reports to the Operational Planning Group on matters relating to operational performance, risk and financial control. The EROC will provide assurance through the Operational Planning Group.

1.14 Accountability Arrangements

Refer to Appendix 1

Environmental Risk Oversight Group Reporting Structure

Appendix 1



H) AREA DRUGS AND THERAPEUTICS COMMITTEE

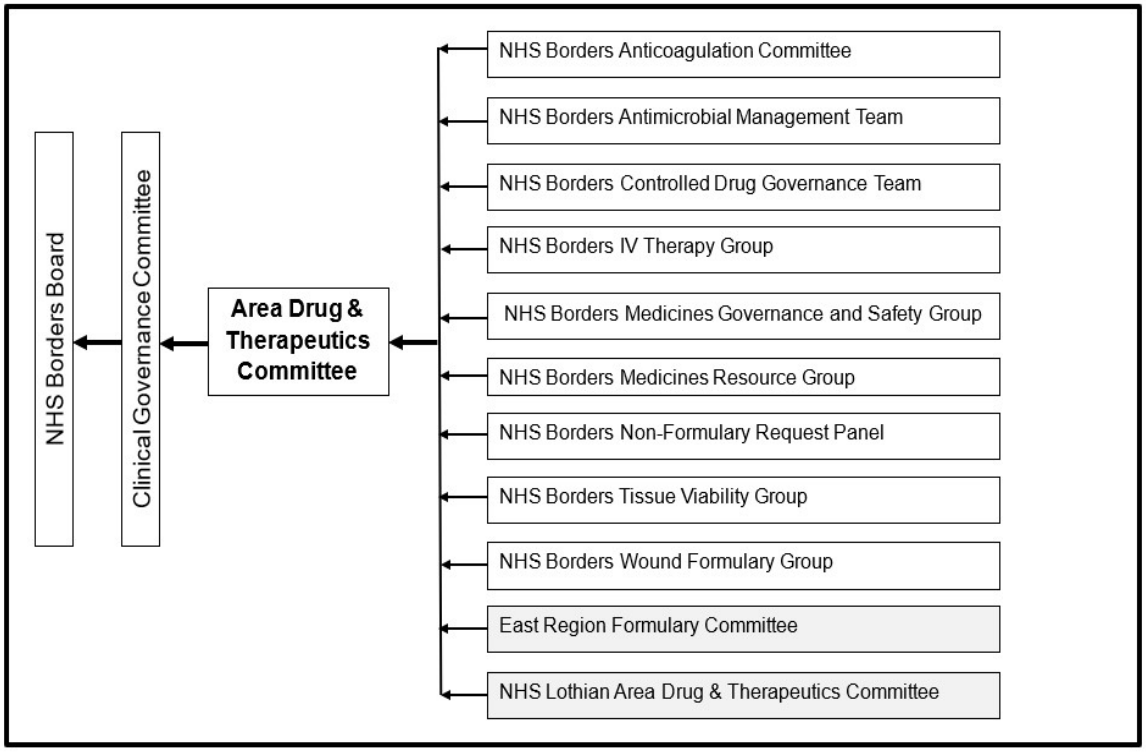
1.1 Purpose

The ADTC provides professional advice and clinical leadership to NHS Borders supporting safe, evidence based, cost effective and patient centred treatment for patients. It provides the governance structure for the use of all types of therapeutic agents (drugs, gases, diet, fluid etc) in NHS Borders, across all care settings. The ADTC is responsible for responding and implementing local and national therapeutic related priorities.

The ADTC is responsible for the implementation of decisions made by the East Region Formulary Committee (ERFC), approval of treatment guidelines in NHS Borders, approval of Patient Group Directions (PGDs), approval of Patient Specific Directions (PSDs), overseeing the medicines safety aspects of the Scottish Patient Safety Programme (SPSP), the Antimicrobial Management Team and all other issues relating to the safe and effective use of medicines.

The ADTC is empowered to form sub-committees and working groups to achieve the above responsibilities.

Where subgroups are convened they should have delegated authority to act on behalf of the ADTC, reporting and referring back to the ADTC where required.



The ADTC submit an annual report to the Clinical Governance Committee (as part of the pharmacy annual report). The chair of the ADTC can be a consultant, lead pharmacist or general practitioner or non- executive member of the Board. The chair of the ADTC should be ratified by the Board.

The ADTC receives and has the opportunity to comment on reports from the Scottish Medicines Consortium and has responsibility for seeking nomination to this group. Once nomination agreed by ADTC it will be sent to the Chief Executive and Medical Director for approval.

1.2 Remit

- To advise and support the strategic direction of all aspects of medicines and therapeutic agents governance and usage in NHS Borders, across all care settings. Governance and usage of therapeutic agents in NHS Borders must be included in the wider strategic planning carried out by the board.
- To ensure multi-stakeholder engagement and joint working on all medicine/therapeutic agent related issues, within all care settings.
- To approve and monitor NHS Borders prescribing policies and treatment guidelines to optimise safe and cost-effective use of medicines.
- To implement the East Region Medicines Collaborative guidelines
- To ensure that ERFC formulary decisions are implemented in practice and reflected in local and regional guidelines.
- Liaise with Clinical Networks and other specialist clinical interest groups to influence and seek advice on aspects of prescribing practice
- To advise, monitor and coordinate the development and approval of policies and procedures which support NHS Borders to meet governance relating to:
    - Prescribing medicines/therapeutic agents (for all prescribers)
    - Administration of medicines/therapeutic agents (by all appropriately trained staff)
    - Safe and secure handling of medicines/therapeutic agents

- To support NHS Borders Board in the delivery of a comprehensive approach to national policy regarding medicines, linking with Regional and National groups.
- To oversee the systems for safer medicines use including SPSP safer medicines group
- To respond to national directives and initiatives related to the use of medicines, in particular those issued by the Sottish Medicines Consortium, Scottish Intercollegiate Guidelines Network (SIGN), National Institute for Healthcare and Clinical Excellence (NICE), Medicines and Healthcare Regulatory Authority (MHRA), National Patient Safety (NPSA) briefings and Major Supply Alert Notices (MSANs)
- To ensure systems are in place for the dissemination of information and advice to professional staff, patients and public promoting safe, efficient and cost-effective use of medicines taking into account current evidence and best practice.
- promote, support and monitor the development of non medical prescribers, including co-ordination of a systematic process to improve access to medicines through Patient Group Directions;
- Work with the Clinical Interface Group to manage prescribing across the primary care-secondary care interface
- encourage participation in the ‘Yellow Card’ scheme for reporting of adverse drug reactions;
- encourage research and audit on cost effective use of medicines;
  develop a system for managing risks identified with the work of the Committee

1.3 Membership

The membership of the committee shall consist of:

Chaired by a consultant, lead pharmacist or general practitioner or non- executive member of the Board. The chair of the ADTC should be ratified by the Board.

The Vice Chair and professional secretary will be chosen from the membership. These individuals will serve a 2-year post and then the positions will rotate to other members. The professional secretary may allocate papers to other members to discuss on behalf of the committee.

Leadership Representation	Medical Representation	Pharmacy Representation	Senior clinical representation	Groups to be represented
•Director of Pharmacy •Clinical Director	•Hospital Physician •General practitioner (x2) •Microbiologist •Surgeon •Anaesthetist	•Lead Pharmacist - Acute •Lead Pharmacist - Medicines Utilisation •Lead Pharmacist Primary care	•Paediatrics •Mental Health •Public Health •Cancer •Lead nurse non medical prescribing	•Primary Care Prescribing Group •East Region Formulary •Area Clinical Forum •Clinical Interface Group

1.4 Frequency of meetings

The ADTC will meet bi-monthly on the fourth Wednesday of the month either via Microsoft teams or face to face as permissible and appropriate.

1.5 Agenda and Papers

The Lead Pharmacist Medicines Utilisation, professional secretary and nominated Committee Administrator will set the agenda for the meetings. The agenda and papers will be circulated at least 5 working days in advance of the meeting. Un-tabled papers will be avoided except in exceptional circumstances.

1.6 Quorum

A quorum will consist of:

- A chair or vice chair
- One pharmacist
- One hospital medical practitioner
- One general practitioner
- One other member of the committee

A roll of attendance will be kept and if members do not attend at least half of the meetings per year they will be asked to attend more regularly or resign. Deputies are to be encouraged. Where quorum is not achieved, the minute should be sent by email to the committee for comment and approval where appropriate if any decisions are made. The chair can then elect to rescind decisions based on the feedback and elect to return the discussion to the next meeting.

1.7 Minutes

Formal minutes will be kept of the proceedings by the committee administrator and reviewed by the professional secretary. These will be submitted for approval at the next ADTC meeting. The draft minutes will be reviewed by the chair and/or vice chair prior to circulation. Once approved, these minutes will be published on the NHS Borders intranet and internet websites.

1.8 Declaration of interest

Declarations of interest will be provided by members of the ADTC on an annual basis and held in confidence for the chair of the committee by the Health Board secretariat. It is the responsibility of the members to declare any possible interests at the beginning of each meeting, or whenever they arise during discussion.

1.9 Operating and reporting arrangements

1. The ADTC is the key professional advisory group for medicines governance and reports into NHS Borders Board via the Boards' clinical governance structures. The committee will communicate reports to the clinical governance at least annual from a scrutiny and assurance perspective. The annual report will be published online.
2. Key decisions will be made, where possible by consensus agreement. Where this is not possible, the committee will decide whether the decision will be taken based on a majority vote or deferred for further discussion.
3. The committee will communicate reports directly to prescribers, other relevant colleagues and committees to avoid unnecessary delay.
4. The committee will communicate reports to the Operation Planning Group in relation to risks to delivery, performance and policy.
5. In order to fill its remit, the ADTC may, within current financial constraints, obtain other professional advice it requires and invite, if necessary, external experts and relevant members of Board staff to attend meetings,
6. Groups reporting to ADTC:
    a. Anticoagulation Committee
    b. Controlled Drug Governance Team
    c. Nutrition Group
    d. Medicines Homecare Group
    e. Non-Formulary Request Panel
    f. Tissue Viability/ Wound Formulary Group
    g. East Region Formulary Committee
    h. Antimicrobial Management Team
    i. IV Therapy Group
    j. Non-Medical Prescribing Group

I) STAFF GOVERNANCE COMMITTEE

1.1 Purpose

To advise the Board on its responsibility, accountability and performance against the NHS Scotland Staff Governance Standard and Whistleblowing Standards; addressing the issues of policy, targets and organisational effectiveness. The NHS Reform (Scotland) Act requires Boards to put and keep in place arrangements for the purpose of improving the management of the officers employed, monitoring such management, and workforce

planning. This will be demonstrated through achievement and progress towards the Staff Governance Standard through:

- Scrutiny of performance against individual elements of the Staff Governance Standards.
- Data collected during the self-assessment audit conducted under the auspices of the Area Partnership Forum.
- The action plans submitted to, and approved by, the Staff Governance Committee.
- iMatter / Everyone Matters / Collecting Your Voices results.
- Whistleblowing activity data.
- Data and information provided in statistical returns reports to the Committee.

1.2 Membership

Membership of the Staff Governance Committee will be:

- A minimum of four Non-Executive Members, one of whom must be the Employee Director and one the Whistleblowing Champion.

In addition there will be in attendance:

- Partnership Leads - Staff-side, from Local Partnership Forums
- Director of People & Culture and Deputy Director(s) of HR
- Other Directors (as appropriate)
- Head of Work & Wellbeing
- OD Lead
- Health & Safety Advisor
- Practice Development Lead

The Chief Executive and Chair will attend at least one Staff Governance Committee meeting per year.

The Committee may invite additional attendees as required by the agenda.

1.3 Meetings

Meetings of the Committee will be quorate when two Non-Executive Members are present.

A Non-Executive Member will act as Chair to the meeting.

1.4 Remit

- To monitor performance of the Health Board against the Staff Governance Standard.
- To fulfil a monitoring, promotion and assurance role with Whistleblowing activity within NHS Borders and ensure compliance with the Once for Scotland/Independent National Whistleblowing Officer Standards.
- To monitor and evaluate Workforce strategies and implementation plans.
- To monitor pay modernisation processes.
- To monitor compliance with Statute and encourage best practice around equality, diversity & inclusion in employment.

- As appropriate, to work collegiately with the Area Partnership Forum (APF) which has the responsibility for ensuring effective partnership working between management and staff at all levels in NHS Borders.
- To receive and note annual reports from the Remuneration Committee.
- To ensure implementation of Once For Scotland Workforce Policies.
- To provide timely Staff Governance information required for national monitoring arrangements.
- To provide Staff Governance information for the Statement of Internal Control.
- To approve and monitor any NHS Borders Workforce Plan.
- To monitor and challenge against the Staff Governance Committee Dashboard data.
- To receive and note National reports on whistleblowing and give assurance to Board on this or escalate concerns to same.
- To receive and note annual report/updates from the OH&S Forum.

1.5 Best value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Borders NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.6 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, is authorised to seek any information it requires from any employee. The Committee is required to review its Terms of Reference on an annual basis.

The Committee is authorised by the Board to obtain independent professional advice and to secure attendance of others with relevant experience and expertise if it considers it necessary.

1.7 Reporting Arrangements

- The Staff Governance Committee reports to Borders NHS Board.
- Following a meeting of the Staff Governance Committee, the Minutes of that meeting should be presented at the next Borders NHS Board meeting.
- The Staff Governance Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Staff Governance Committee.
- The Staff Governance Committee will produce an Annual Report for presentation to Borders NHS Board. The Annual Report will describe the outcomes from the Committee during the year and provide an assurance to the Board that the Committee has met its remit during the year. The Annual Report must be presented to a Board meeting prior to the Audit & Risk Committee considering the Annual Accounts.

J) REMUNERATION COMMITTEE

1.1 Purpose

The fourth edition of the Staff Governance Standard made clear that each NHSScotland Board is required to establish a Remuneration Committee, whose main function is to ensure application and implementation of fair and equitable pay systems on behalf of the Board as determined by Ministers and the Scottish Government and applies to Executives and Senior Managers only.

1.2 Composition

- The Chair of the Board
- The Vice Chair of the Board
- The Employee Director
- Two other Non-Executive Members

The Chair and Employee Director will not chair the Committee.

In addition there may be in attendance:

- Board Secretary
- Chief Executive
- Director of People & Culture
- Deputy Director of HR

At the request of the Committee, other Senior Officers may also be invited to attend.

All members of the Remuneration Committee will require to be appropriately trained to carry out their role on the Committee.

No employee of the Board shall be present when any issue relating to their employment is being discussed.

1.3 Meetings

The Committee will meet no less than 3 times per annum**.**

Remuneration issues may arise between meetings and will be brought to the attention of the Chair of the Remuneration Committee by the Chief Executive or the Director of People & Culture. The Chair may call a special meeting of the Remuneration Committee to address the issue.

Meetings of the Committee will be quorate when three Non-Executive Members are present.

1.4 Remit

The Remuneration Committee will oversee the remuneration arrangements for Executive Directors and others under the Executive Cohort and Senior Manager Pay Systems and also to discharge specific responsibilities on behalf of the Board as an employing organisation.

Ensure that arrangements are in place to comply with NHS Borders Performance Assessment Agreement and Scottish Government direction and guidance for determining

the employment, remuneration, terms and conditions of employment for Executive Directors, in particular:-

- approving the personal objectives of all Executive Directors in the context of NHS Borders's Annual Delivery Plan, Corporate Objectives and other local, regional and national policy;

- receiving formal reports on the operation of remuneration arrangements and the outcomes of the annual assessment of performance and remuneration for each of the Executive Directors.

Ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for other staff employed under the 'Executive Cohort' and 'Senior Manager' pay systems. The Committee will receive formal reports annually providing evidence of the effective operation of these arrangements.

Promote the adoption of an NHS Borders approach to issues of remuneration and performance assessment to ensure consistency.

Undertake reviews of aspects of remuneration/employment policy for Executive Directors (e.g. Relocation Policy) and other Senior staff (e.g. special remuneration), when requested by NHS Borders Board.

The Remuneration Committee shall approve, reject or seek amendment to proposed severance packages ie financial packages to incentivise an employee leaving the employment of NHS Borders by mutual consent. These are usually progressed through use of a Settlement Agreement which is a legal document which requires ultimate sign off by Scottish Government. Where matters are time critical, the proposal may be circulated around the Remuneration Committee by email, if there is no upcoming formal meeting.

Consider and keep under regular review the arrangements for those NHS Borders staff on external secondments.

To be assured as to the proper processes of the Discretionary Points Committee in the award of discretionary points to eligible specialist, medical and dental staff based on competent recommendations from the appropriate advisory bodies, and to receive reports from the Committee for approval.

To have oversight of the consultant recruitment process on behalf of the Board, who are responsible for the recruitment, and authorisation of appointments of, consultants as required under the National Health Service (Appointment of Consultants) (Scotland) Regulation 2009.

1.4.1 Confidentiality and Committee Decisions

Decisions reached by the Committee will be by agreement and with all Members agreeing to abide by such decisions (to the extent that they are in accordance with the constitution of the Committee). All Members will treat the business of the Committee as confidential. The Committee may in certain circumstances decide a voting approach is required with the Chair having a second and casting vote.

1.4.2 Minutes and Reports

Reports issued to Members will contain full details of the issues to be considered with clear recommendations to the Committee. The minutes will record the decisions reached by the Committee with due regard to confidentiality in relation to individuals.

1.5 Best value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from the Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.6 Authority

The Remuneration Committee is authorised by the Board to investigate any activity within its terms of reference, and in doing so, is authorised to seek any information it requires about any employee.

In order to fulfil its remit, the Remuneration Committee may obtain whatever professional advice it requires, and it may require Directors or other officers of NHS Borders to attend meetings.

1.7 Reporting Arrangements

The Remuneration Committee reports through the Staff Governance Committee to the Board;

Following a meeting of the Remuneration Committee the minutes of that meeting shall be marked as “confidential” and made available to the Non Executive Directors.

The Remuneration Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Remuneration Committee.

The Remuneration Committee will produce a high level Annual Report for presentation to the Staff Governance Committee to provide assurance that the Remuneration Committee is addressing appropriate business in line with due process.

The Remuneration Committee will through the Staff Governance Committee provide an annual assurance that systems and procedures are in place to manage the pay arrangements for all Executive Directors and others under the Executive Cohort and Senior Manager pay systems so that overarching Staff Governance responsibilities can be discharged. The Staff Governance Committee will not be given the detail of confidential employment issues that are considered by the Remuneration Committee; these can only be considered by the Non-Executive Members of the Board.

The Annual Report will be prepared as close as possible to the end of the financial year but in enough time to allow it to be considered by the Staff Governance Committee. This is to ensure that the Staff Governance Committee is in a position in its annual report to provide the annual assurance that systems and procedures are in place to manage the pay arrangements for all staff employed in NHS Borders.

1.8 Review

The Terms of Reference of the Remuneration Committee will be reviewed on an annual basis. The Remuneration Committee will undertake an annual self assessment.

K) AREA CLINICAL FORUM (ACF)

The Area Clinical Forum is constituted under "Rebuilding our National Health Service" - A Change Programme for Implementing "Our National Health, Plan for Action, A Plan for Change", which emphasised that NHS Boards should both:-

- Draw on the full range of professional skills and expertise in their area for advice on clinical matters both locally and on national policy issues;

- Promote efficient and effective systems - encouraging the active involvement of all clinicians from across their local NHS system in the decision-making process to support the NHS Board in the conduct of its business.

1.1 Purpose

To formulate comprehensive clinical advice to the Board on matters of policy and implementation. The Committee will consult widely with its constituency and the Board. It will be pro-active in:

- reviewing the business of professional advisory committees to ensure co-ordination of clinical matters across each of the professional groups;

- the provision of a clinical perspective on the development of the Local Delivery Plan and the strategic objectives of the NHS Board;

- sharing best practice and encouraging multi-professional working in healthcare and health improvement;

- ensuring effective and efficient engagement of clinicians in service design, development and improvement;

- providing a local clinical and professional perspective on national policy issues;

- Ensuring that local strategic and corporate developments fully reflect clinical service delivery;

- Taking an integrated clinical and professional perspective on the impact of national policies at local level;

- Through the ACF Chair, being fully engaged in NHS Board business; and

- supporting the NHS Board in the conduct of its business through the provision of multi-professional clinical advice.

At the request of Borders NHS Board, the Area Clinical Forum may also be called upon to perform one or more of the following functions:-

- Investigate and take forward particular issues on which clinical input is required on behalf of the Board where there is particular need for multi- disciplinary advice.

- Advise Borders NHS Board of the impact of national policies on the integration of services, both within the local NHS systems and across health and social care.

Authority: The Area Clinical Forum is an Advisory Committee of the Borders NHS Board.

Reporting Arrangements: The Area Clinical Forum will report to Borders NHS Board and submit an Annual Report on its activities to the NHS Board.

The approved minutes of the ACF will be presented in to the next NHS Board meeting to ensure NHS Board members are aware of issues considered and decisions taken.

Membership: The Area Clinical Forum will consist of the chair, vice chair and another identified representative of each of the statutory Area Professional Committees as follows:-

- Area Allied Health Professionals Committee
- Area Medical Committee
- Area Dental Committee
- Area Optical Committee
- Area Nursing and Midwifery Committee
- Area Pharmaceutical Committee
- Healthcare Scientists Advisory Committee
- Psychologists Team

Others in Attendance: The Committee may invite others to attend a meeting for discussion of specific items. That person may take part in the discussion but will not have a vote.

Sub Committees: The Committee may appoint ad hoc Short Life Working Sub-Committees as appropriate to consider and provide advice on specific issues.

Tenure: Individual members tenure will be determined by the constitution of their parent Committee. If a member resigns or retires, the appropriate Advisory Committee will choose a replacement. Individuals shall cease to be members of the Area Clinical Forum on ceasing to be the Chair, Vice Chair or identified representative of their professional committee.

Officers

Chair: The Committee shall elect a Chair. This shall be on the basis of one vote for each of the Committee members. The Chair shall be elected for 4 years in line with the appointment tenure of Non Executives to the Board. He/she will be eligible for a maximum of 2 consecutive terms of office.

Selection of the Chair will be an open process, and all members may put themselves forward as candidates for the position. If more than one person puts themselves forward an election will be held by secret ballot (Annex A).

The Chair of the Area Clinical Forum will, subject to formal appointment by the Cabinet Secretary for Health and Wellbeing, serve as a Non-Executive member of Borders NHS Board.

Membership of Borders NHS Board is specific to the office rather than to the person. The normal term of appointment for Board members is for a period up to four years. Appointments may be renewed, subject to Ministerial approval.

Where the members of the Area Clinical Forum choose to replace the Chair before the expiry of their term of appointment as a Non-Executive member of Borders NHS Board, the new Chair will have to be formally nominated to the Cabinet Secretary as a Non-Executive member of Borders NHS Board for approval.

In the same way, if Board Membership expires and is not renewed, the individual must resign as Chair of the Area Clinical Forum, but may continue as a member of the Area Clinical Forum.

Vice-Chair: The Committee shall then elect a Vice-Chair. The tenure shall be the same as for the Chair.

A Vice Chair of the Area Clinical Forum will be chosen by the Members of the Forum from among their number. Selection of the Vice Chair of the Forum will be an open process and all members may put themselves forward as candidates for the position. If more than one person puts themself forward an election will be held by secret ballot.

The Vice Chair will deputise, as appropriate, for the Chair, but where this involves participation in the business of Borders NHS Board, they will not be functioning as a Non-Executive member.

Secretary: The Secretary shall be provided by the NHS Board.

Conditions

Interests: Members must declare any pecuniary or other interest which could be construed as influencing the advice given to the NHS Board, and must not participate in discussion leading to that advice.

Removal: An Office Bearer may be removed from office at a meeting of the Committee only if the removal has been included as an agenda item. Such removal would require the agreement of two thirds of the members of the Committee.

Executive Powers: The Chair (or in his/her absence the Vice Chair) will have discretionary powers to act on behalf of the Committee but in doing so is answerable to the Committee.

Membership of the NHS Board: The Chair will be appointed by the Cabinet Secretary as a full member of Borders NHS Board.

Conduct: All members will have due regard to and operate within NHS Borders Code of Corporate Governance.

Standing Orders

Notice of Meetings: The Secretary will ensure that the agenda and relevant papers are issued at least seven days before the meeting whenever possible.

Minutes: The Secretary will ensure that the minutes of the meetings of the Committee are sent to the each member with the agenda and papers of the next meeting.

Meetings: Meetings will be held bi-monthly although the Committee may vary these arrangements to cover holiday months or other circumstances.

Quorum: A quorum of the Committee will be one third of the members. In the event that the Chair and Vice Chair are both absent, the members present shall elect from those in attendance, a person to act as chair for the meeting.

Voting: Where the Committee is asked to give advice on a matter and a majority vote is reached the Chair or Secretary will record the majority view but will also make known any significant minority opinion and present the supporting arguments for both view points.

Alterations to the Constitution and Standing Orders: Alterations to the Constitution and Standing Orders may be recommended at any meeting of the Committee provided notice of the proposed alteration is circulated with the notice of the meeting and that the proposal is seconded and supported by two-thirds of the members present and voting at the meeting.

Any alterations must be submitted to the NHS Board for approval.

ANNEX A

ACF CHAIR ELECTION PROCESS

- Election to be carried out during ACF meeting.
- The current chair will ask for nominations from the ACF members and check nominees willingness to stand for election.
- If there is more than 1 nominee each will be asked to briefly inform the ACF what will be their approach to the role, how they will involve the members and how they will develop the ACF (no more than 5 minutes each).
- Each ACF member will have 1 vote (they may vote for themselves).
- Each member will write their chosen candidate on a paper slip and pass to the secretary.
- The Board Secretary will check the votes and announce the winner.
- In the event of a draw then the Board Secretary will announce this to the ACF.

- Candidates will be asked if they wish to add anything to their earlier statements.

- The ACF members will then vote again.

- If there is a second draw the Board Secretary will announce this and the Chair will ask the members if they are likely to change their vote.

- If not then the decision will be referred to a panel of 3 Non Executive Directors. Candidates will give a short presentation to the panel on their approach to the role, how they will involve the members and how they will develop the ACF.

- The panel will then make a decision and inform the existing Chair.

- Once a decision is made the Board Secretary will then make the appropriate arrangements.

- The ACF Vice Chair will be appointed via the same process

L) AREA PARTNERSHIP FORUM (APF)

1. PURPOSE

The Area Partnership Forum is a strategic body which is responsible for facilitating, monitoring and evaluating the effective operation of partnership working across NHS Borders. It further acts to endorse HR policies, procedures & protocols through the partnership process, recognising the Once for Scotland context.

1.1 Remit

The Area Partnership Forum will:

- Take a proactive approach in embedding partnership working at all levels of the organisation to assist the process of devolved decision making and to develop effective working relationships.
- Endorse, implement & monitor adherence to all HR Policies.
- Consider and comment on other corporate policies/strategies, assessing the impact of strategic decisions upon staff and making sure policies are underpinned by appropriate Staff Governance and financial planning disciplines.
- Support the work of the Staff Governance Committee.
- Ensure the best HR practice is shared across the health board.
- Contribute to the development of strategies and action plans.
- Oversee, monitor and evaluate the roll-out of staff surveys.
- Liaise with national industrial relations bodies such as the Scottish Partnership Forum and STAC.
- Contribute to local and regional planning arrangements.
- Ensure adequate and necessary Facilities Arrangements are in place.
- Making sure that the views of all Staff Side with an interest in improving local health and healthcare services, local communities and healthcare staff are appropriately heard and considered.

- Ensure the Area Partnership Forum has knowledge and understanding of national issues.
- Ensure that in its close working with the Training, Education & Development (TED) Board, that all staff, are effectively trained, properly supported and performance is formally reviewed on an annual basis.

1.2 Authority

The Forum is authorised by NHS Borders to investigate any activity within its terms of reference. In order to fulfil its remit, the Area Partnership Forum may obtain whatever professional advice it requires (including that from professional/trade union/national or local representatives) and require Directors or other officers of the Board to attend meetings.

The external Auditor and Chief Internal Auditor shall have the right of direct access to the Joint Chairs of the Area Partnership Forum.

The Forum is authorised by the Board to endorse & adopt Once for Scotland HR policies and any other more localised protocols through the partnership process.

1.3 Reporting Arrangements

- The Area Partnership Forum acts as a sub-group of, and reports to, the Staff Governance Committee which in turn is a sub-committee of the Board.
- Following a meeting of the Area Partnership Forum, the approved minutes of that meeting will be presented for information at the next meeting of the Staff Governance Committee.
- The Area Partnership Forum shall annually and within three months of the start of each financial year provide, approve and agree a workplan detailing the work to be taken forward by the Forum that year.
- The Area Partnership Forum shall produce an annual report for presentation to the APF and Staff Governance Committee that will describe outcomes from the Forum during the year.

2. MEMBERSHIP

Membership of the Area Partnership Forum shall comprise representatives of management and all recognised staff organisations (Staff Side). [Appendix 1]. For any voting purposed each recognised Trades Union will have one seat/one vote. However, all Staff Side representatives are encouraged to attend.

Management and Staff Side should have named members with nominated deputies. Management and Staff Side representatives, including deputies, may attend as observers with the agreement of the Joint Chairs. Full Time Officers for recognised Staff Side organisations may attend as an ex-officio member.

Membership (and Deputy Membership) is conferred without limit of time subject to acceptable record of attendance. Membership will be formally updated annually when the Terms of Reference are reviewed.

The Employee Director's Offices shall ensure that an accurate record of attendance is maintained and absence from three consecutive meetings of the Forum shall result in membership being withdrawn and alternative representation being sought.

Should there then be continued non-attendance of a nominated representative to the APF, the Joint Chairs shall contact the nominated representative and/or (in the case of a Staff Side representative) their relevant staff organisation and clarify if the nominated representative wishes to continue as a member of the APF, or if another nominated representative from that organisation will be replacing them on the APF.

2.1 Formal Subgroups

Local Partnership Forums x 4
Pay And Conditions of Employment (PACE) Group
Joint Staff Forum, with IJB

The Area Partnership Forum will also act as a resource for other groups seeking Staff Side views / opinions relating to NHS Borders matters.

The Occupational Health and Safety Forum, as a statutory committee for Health and Safety, will communicate directly to the Area Partnership Forum and Staff Governance Committee on matters agreed in partnership with managers and health and safety representatives. The OH&S Forum is not a sub-committee of APF.

The Staff Wellbeing Group is a subgroup of the Occupational Health and Safety Committee and is not a subgroup of APF but will report on an agreed basis to the APF.

3. FORUM MEETINGS

3.1 Cycle of Meetings

The Forum will meet on an agreed basis, but routinely every 8 weeks, unless otherwise agreed by the Joint Chairs.

3.2 Chairing of Meetings

The Chief Executive and Employee Director will take on responsibility of Chairing the APF (in accordance with National Guidance) and will do so alternately. If neither are available, they can with joint agreement request another member of the forum to Chair. It is the responsibility of the Joint Chairs to agree in advance any agenda items. The Employee Director's Offices shall distribute an agenda and supporting papers for each Forum meeting no later than one week before the date of the meeting to all Forum members.

3.3 Quorum

The Forum will be quorate when:

- a minimum of five members of the Management.
- a minimum of five members of the Staff Side is present.

4. VALUES

To underpin the working of the Area Partnership Forum, the following values will be adopted and govern the approach taken to consideration of issues, in line with the requirements of MEL (1999) 59:

- mutual trust, honesty and respect.
- openness and transparency in communications.
- recognising and valuing the contribution of all partners.
- access and sharing of information.
- consensus, collaboration and inclusion.
- maximising employment security.
- full commitment to the framework and good employment practice.
- the right of stakeholders to be involved, informed and consulted.
- early involvement of all staff and their trade unions in all discussions regarding change.
- a team approach to underpin partnership working.

The Forum will also promote and act in accordance with the Partnership Standards for NHS Borders.

5. DECISION OF THE FORUM

5.1 Consultation

Any party may request that a matter brought before the Forum be subject to appropriate consultation with management and Staff Side colleagues prior to any final agreement being reached.

Decisions reached by the Forum which impact on the operation of policy and practice will take effect from a date agreed by the parties and will apply to all relevant staff employed within NHS Borders.

5.2 Referral

Any matter considered by the Area Partnership Forum which is deemed to fall outwith its terms of reference, or which is subject to Board or Staff Governance Committee approval, will be referred to the Board or Staff Governance Committee on the basis of Area Partnership Forum support. Reference to the Scottish Partnership Forum may also take place as appropriate.

5.3 Failure to Agree

In the event of any failure to agree matters under consideration, the matter will be referred via the Chair to the Staff Governance Committee, who will endeavour to find a way forward.

6. Review

These Terms of Reference will be reviewed on an annual basis and before the end of June each year.

APPENDIX 1
Management Representatives

The management representatives will be drawn from the senior officers of NHS Borders and will normally include:

- Chief Executive
- Director of People & Culture (plus deputies)
- Director of Acute Services
- Chief Officer, IJB
- Director of Planning & Performance
- Director of Finance (or deputy)
- Director of Nursing, Midwifery & AHPs (or deputy)
- Associate Director of AHPs
- Head of Estates & Head of Facilities
- General Managers
- Representative of the Communications Department

Other management representatives may attend in response to specific issues under consideration at the Forum

Staff Side Organisations

- British Association of Occupational Therapy – BAOT
- British Dental Association – BDA
- British Dietetic Association – BDA
- British Medical Association – BMA
- British and Orthoptic Society - BIOS
- Community and District Nursing Association
- Community Practitioners and Health Visitors Association
- Chartered Society of Physiotherapy – CSP
- General Municipal Boilermakers Union – GMB
- Royal College of Nursing – RCN
- Royal College of Midwives – RCM
- Society of Chiropodists & Podiatrists – SCP
- Society of Radiographers – SOR
- UNISON
- UNITE

The Chairs of the Local Partnership Forums attend using either their Trade Union seat or in an ex-officio capacity.

Fulltime Union Officials attend in an ex-officio capacity.

M) PHARMACY PRACTICES COMMITTEE

Terms of Reference

The Pharmacy Practices Committee is constituted and operates in compliance with the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995. Statutory Instrument 1995 No 414 (S.28).

Appendix 1

SCOTTISH STATUTORY INSTRUMENTS

2001 No. 302

NATIONAL HEALTH SERVICE

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001

Made	*6th September 2001*
Laid before the Scottish Parliament	*7th September 2001*
Coming into force	*28th September 2001*

ARRANGEMENT OF REGULATIONS

PART IV

MISCELLANEOUS

12. Revocations

SCHEDULE: Meetings and proceedings of the Board and committees

The Scottish Ministers, in exercise of the powers conferred by sections 2(10), 105(7) and 108(1) of, and by paragraphs 2A, 4, 6 and 11 of Schedule 1 to the National Health Service (Scotland) Act 1978(a), and of all other powers enabling them in that behalf, hereby make the following Regulations:

PART I

GENERAL

Citation, commencement and interpretation

1.—(1) These Regulations may be cited as the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 and shall come into force on 28th September 2001.

(2) In these Regulations, unless the context otherwise requires–

"the 1997 Act" means the National Health Service Act 1977(b);

"the Act" means the National Health Service (Scotland) Act 1978;

"Board" means a Health Board constituted under section 2(1) of the Act;

"the Charity Commissioners" means the Charity Commissioners constituted in accordance with section 1 of the Charities Act 1993(c);

"Chief Officer" means the person or persons holding the post of Chief Executive;

"committee" means a committee of a Board and includes "sub-committee"

"contract" includes any arrangement including a NHS contract;

"health service body" means a person or body specified in section 17A(2) of the Act(d);

"meeting" means a meeting of the Board or of any committee;

"member" means a member of a Board and includes the chairperson;

"NHS trust" means a National Health Service trust established under section 12A of the Act(e).

(3) A reference in these Regulations to a numbered regulation is to the regulation bearing that number in these Regulations and a reference in a regulation to a numbered paragraph is to the paragraph bearing that number in that regulation and a reference to the Schedule is to the Schedule to these Regulations.

(a) 1978 c.29; section 105(7), which was amended by the Health Services Act 1980 (c.53) ("the 1980 Act"), Schedule 6, paragraph 5(1)(a) and Schedule 7 and by the Health and Social Services and Social Security Adjudications Act 1983 (c.41) ("the 1983 Act"), Schedule 9, paragraph 24, contains provisions relevant to the exercise of the statutory powers under which these Regulations are made; section 108(1) contains definitions of "prescribed" and "regulations" relevant to the exercise of the statutory powers under which these Regulations are made; paragraph 2A of Schedule 1 was inserted by the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), Schedule 5, paragraph 2; paragraph 4 of Schedule 1 was amended by the 1990 Act, Schedule 5, paragraph 3; and paragraph 11 of Schedule 1 was amended by the 1980 Act, Schedule 6, paragraph 7 and Schedule 7 and by the 1990 Act, Schedule 5, paragraph 7. The functions of the Secretary of State were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998 (c.46).

(b) 1977 c.49.

(c) 1993 c.10.

(d) Section 17A(2) was inserted by the 1990 Act, section 30 and amended by the Health Act 1999 (c.8), Schedule 1.

(e) Section 12A was inserted by the 1990 Act, section 31 and amended by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2, paragraph 46 and by the Health Act 1999 (c.8), sections 46 and 48 and Schedule 4, paragraph 45.

PART II

MEMBERSHIP

Appointment and term of office

2.—(1) All members shall be appointed by the Scottish Ministers.

(2) The term of office of the members shall, subject to regulation 5, be for such period as the Scottish Ministers shall specify on making the appointment.

(3) After the expiration of a term of office a member shall, subject to regulation 6, be eligible for re-appointment.

University members

3. For the purposes of paragraph 2A of Schedule 1 to the Act(a) the Boards in which at least one of the persons appointed to be chairperson or a member must hold a post in a university with a medical or dental school are the Boards in Grampian, Greater Glasgow, Lothian and Tayside.

Remuneration of members

4. Remuneration may be paid, in accordance with such determination as may be made by the Scottish Ministers, under paragraph 4 of Schedule 1 to the Act(b), to the chairperson, a member appointed under paragraph 2A of Schedule 1 to the Act holding a post in a university and any of the other members, except any members holding the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust.

Resignation and removal of members

5.—(1) A member may resign office at any time during the period of appointment by giving notice in writing to the Scottish Ministers to this effect.

(2) If the Scottish Ministers consider that it is not in the interests of the health service that a member of a Board should continue to hold that office they may forthwith terminate that person's appointment.

(3) If a member has not attended any meeting of the Board, or of any committee of which they are a member, for a period of six consecutive months, the Scottish Ministers shall forthwith terminate that person's appointment unless the Scottish Ministers are satisfied that–

(a) the absence was due to illness or other reasonable cause; and

(b) the member will be able to attend meetings within such period as the Scottish Ministers consider reasonable.

(4) Where a member who was appointed for the purposes of paragraph 2A of Schedule 1 to the Act ceases to hold the post in a university with a medical or dental school, which was held at the time of appointment for those purposes, the Scottish Ministers may terminate the appointment of that person as a member.

(5) Where any member becomes disqualified in terms of regulation 6 that member shall forthwith cease to be a member.

Disqualification

6.—(1) Subject to paragraphs (2) and (3), a person shall be disqualified for being a member, if–

(a) they have, within the period of five years immediately preceding the proposed date of appointment, been convicted in the United Kingdom, the Channel Islands, the Isle of Man or the Irish Republic of any offence in respect of which they have received a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine;

(b) their estate has been sequestrated in Scotland or they have otherwise been adjudged bankrupt elsewhere than in Scotland, they have granted a trust deed for the benefit of

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(a) Paragraph 2A was inserted by the 1990 Act, Schedule 5, paragraph 2.
(b) Paragraph 4 was amended by the 1990 Act, Schedule 5, paragraph 3.

their creditors or entered into any arrangement with their creditors, or a curator bonis or judicial factor has been appointed over their affairs;

(c) they have resigned or been removed or been dismissed, otherwise than by reason of redundancy, from any paid employment or office with a health service body;

(d) they are a person whose appointment as the chairperson, member or director of a health service body has been terminated other than by the expiration of their term of office;

(e) they are a chairperson, member, director or employee of a health service body;

(f) they have had their name removed, by a direction under section 29 of the Act(a), from any list prepared under Part II of the Act and have not subsequently had their name included in such a list;

(g) they are a person whose name has been included in any list prepared under Part II of the Act, and whose name has been withdrawn from the list on their own application;

(h) they have had their name removed, by a direction under section 46 of the 1977 Act(b) from any list prepared under Part II of the 1977 Act and have not subsequently had their name included in such a list;

(i) they are a person whose name has been included in any list prepared under Part II of the 1977 Act, and whose name has been withdrawn from the list on their own application;

(j) they are a person who is subject to a disqualification order under the Company Directors Disqualification Act 1986(c); or

(k) they are a person who has been removed from the position of trustee of a charity, whether by the court or by the Charity Commissioner.

(2) For the purpose of paragraph (1)–

(a) the disqualification attaching to a person whose estate has been sequestrated shall cease if and when–

(i) the sequestration of their estate is recalled or reduced; or

(ii) the sequestration is discharged;

(b) the disqualification attaching to a person by reason of their having been adjudged bankrupt shall cease if and when–

(i) the bankruptcy is annulled; or

(ii) they are discharged;

(c) the disqualification attaching to a person in relation to whose estate a judicial factor has been appointed shall cease if and when–

(i) that appointment is recalled; or

(ii) the judicial factor is discharged;

(d) the disqualification attaching to a person who has granted a trust deed or entered into an arrangement with their creditors shall cease if and when that person pays their creditors in full or on the expiry of five years from the date of their granting the deed or entering into the arrangement.

(3) The Scottish Ministers may direct that in relation to any individual person or Board any disqualification so directed shall not apply in relation thereto.

(4) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the days of appeal expire without any appeal having been lodged, or if an appeal has been made, the date on which the appeal is finally disposed of or treated as having been abandoned.

Appointment and powers of vice-chairperson

7.—(1) For the purpose of enabling the business of a Board to be conducted in the absence of the chairperson, each Board shall appoint a member who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust to be vice-chairperson and any person so appointed shall, so long as they remain a member of the Board, hold office as vice-chairperson for such period as the Board may decide.

(a) Section 29 was amended by the Health and Social Security Act 1984 (c.48), Schedule 8 and by the National Health Service (Amendment) Act 1995 (c.31), section 7 and the Schedule.

(b) Section 46 was amended by the Health Authorities Act 1995 (c.17), Schedule 1 and the National Health Service (Amendment) Act 1995 (c.31), sections 1, 2 and 3.

(c) 1986 c.46.

(2) Any member so appointed may at any time resign from the office of vice-chairperson by giving notice in writing to the chairperson and the members may appoint another member as vice-chairperson in accordance with paragraph (1).

(3) Where the chairperson of a Board has died or has ceased to hold office of where that person has been unable to perform their duties as chairperson owing to illness, absence from Scotland or any other cause, the vice-chairperson shall take the place of the chairperson in the conduct of the business of the Board and references to the chairperson shall, so long as there is no chairperson able to perform their duties, be taken to include references to the vice-chairperson.

PART III

PROCEEDINGS

Meetings and minutes

8.—(1) The meetings and proceedings of the Board shall be conducted in accordance with standing orders made pursuant to regulation 9.

(2) At every meeting of a Board, the chairperson, if present, shall preside.

(3) If the chairperson is absent from any meeting, the vice-chairperson, if present, shall preside, and if the chairperson and vice-chairperson are both absent, the members present at the meeting shall elect from among themselves a person, who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust, to act as chairperson for that meeting.

(4) All acts of, and all questions coming and arising before, a Board shall be done and decided by a majority of the members of the Board present and voting at a meeting of the Board and, in the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote.

(5) The proceedings of a Board or of any committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of any member of such committee.

Standing orders

9.—(1) Subject to paragraph (2) and to such directions as may be given by the Scottish Ministers, each Board shall make, and may vary and revoke, standing orders for the regulation of the procedure and business of the Board and of any committee.

(2) Standing Orders under paragraph (1) should include the matters set out in the Schedule.

Appointment and functions of committees

10.—(1) A Board may, and if so directed by the Scottish Ministers shall, appoint committees for such purposes as the Board may determine, subject to such restrictions or conditions as the Board may think fit, or as the Scottish Ministers may direct.

(2) Any committee, but not including any sub-committee, appointed under paragraph (1) shall include at least one member of the Board and may include persons, including trustees of a NHS trust, who are co-opted, and may consist wholly or partly of members of the Board.

(3) Any sub-committee appointed under paragraph (1) may include persons who are co-opted and may consist wholly or partly of members of the Board or wholly of persons who are not members of the Board.

Conflict of interest

11.—(1) Subject to such exceptions and qualifications as may, with the approval of the Scottish Ministers, be specified in standing orders, if a member, or associate of theirs has any pecuniary or other interest, direct or indirect, in any contract or proposed contract (not being a contract for the provision of any of the services mentioned in Part II of the Act) or other matter, and that member is present at a meeting of the Board or of a committee at which the contract or other matter is the subject of consideration, they shall at the meeting, and as soon as practicable after its

commencement, disclose the fact, and shall not take part in the consideration and discussion of, the contract, proposed contract or other matter or vote on any question with respect to it.

(2) The Scottish Ministers may, subject to such conditions as they may think fit to impose, remove any disability imposed by this regulation in any case in which it appears to them in the interests of the health service that the disability should be removed.

(3) Any remuneration, compensation or allowances payable to a chairperson or other member by virtue of paragraphs 4, 5 or 13 of Schedule 1 to the Act shall not be treated as a pecuniary interest for the purpose of this regulation.

(4) A member shall not be treated as having an interest in any contract, proposed contract or other matter by reason only that they, or an associate of theirs, has an interest in any company, body or person which is so remote or insignificant that they cannot reasonably be regarded as likely to effect any influence in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

(5) This regulation applies to a committee as it applies to the Board and applies to any member of any such committee (whether or not they are also a member of the Board) as it applies to a member of the Board.

(6) For the purposes of this regulation, the word "associate" has the meaning given by section 74 of the Bankruptcy (Scotland) Act 1985(a).

PART IV

MISCELLANEOUS

Revocations

12. The following Regulations are hereby revoked:–

(a) the Health Boards (Membership and Procedure) (No. 2) Regulations 1991(b)

(b) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1993(c)

(c) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1998(d)

(d) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1999(e).

SUSAN C DEACON
A member of the Scottish Executive

St Andrew's House,
Edinburgh
6th September 2001

(a) 1985 c.66. Section 74 was amended by the Bankruptcy (Scotland) Regulations 1985 (S.I. 1985/1925), regulation 11.
(b) S.I 1991/809.
(c) S.I. 1993/1615.
(d) S.I. 1998/1459.
(e) S.I. 1999/132.

Regulation 9

SCHEDULE

MATTERS TO BE INCLUDED IN STANDING ORDERS REGULATING MEETINGS AND PROCEEDINGS OF THE BOARD AND COMMITTEES

Calling meetings

1.—(1) The first meeting of the Board shall be held on such day and at such place as may be fixed by the chairperson and that person shall be responsible for convening the meeting.

(2) The chairperson may call a meeting of the Board at any time and the chairperson of a committee may call a meeting of that committee at any time or and shall call a meeting when required to do so by the Board.

(3) If the chairperson refuses to call a meeting of the Board after a requisition for that purpose specifying the business proposed to be transacted, signed by at least one third of the whole number of members, has been presented to the chairperson or if, without so refusing, the chairperson does not call a meeting within 7 days after such requisition has been presented, those members who presented the requisition may forthwith call a meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

Notice of Meetings

2.—(1) Before each meeting of the Board, a notice of the meeting, specifying the time, place and business proposed to be transacted at it and signed by the chairperson, or by a member authorised by the chairperson to sign on that person's behalf, shall be delivered to every member or sent by post to the usual place of residence of such members so as to be available to them at least three clear days before the meeting.

(2) Lack of service of the notice on any member shall not affect the validity of a meeting.

(3) In the case of a meeting of the Board called by members in default of the chairperson, the notice shall be signed by those members who requisitioned the meeting in accordance with paragraph 1(3).

Conflict of interests

3.—(1) A member shall be excluded from a meeting of the Board or committee in accordance with regulation 11 while any contract, proposed contract, or other matter in which they or an associate of theirs has an interest is under consideration.

(2) The exceptions and qualifications referred to in regulation 11(1) shall be specified.

Quorum

4. No business shall be transacted at a meeting of the Board unless there are present, and entitled to vote, at least one third of the whole number of members including at least two members who do not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust.

Conduct of meetings

5.—(1) At any meeting of a committee the chairperson of that committee, if present, shall preside.

(2) If both the chairperson and vice-chairperson (if any) are absent from a meeting of the Board a member, who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust, chosen at the meeting by the members present shall preside.

(3) If both the chairperson and vice-chairperson (if any) of a committee are absent from a meeting of that committee a member of the committee chosen at the meeting by the other members present shall preside.

(4) If it is necessary or expedient to do so a meeting may be adjourned to another day, time and place.

Voting

6. Every question at a meeting shall be determined by a majority of the votes of the members present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

Records

7.—(1) The names of the members present at a meeting shall be recorded.

(2) The minutes of the proceedings of a meeting including any decision or resolution made at that meeting shall be drawn up and submitted to the next ensuing meeting for agreement after which they will be signed by the person presiding at that meeting.

Suspension and disqualification

8. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

EXPLANATORY NOTE

(This note is not part of the Order)

These Regulations supersede and revoke the Health Boards (Membership and Procedure) (No. 2) Regulations 1991 ("the 1991 Regulations") and their amendments, the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1993, the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1998 and the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1999.

The Regulations, make provision in relation to Boards established under the National Health Service (Scotland) Act 1978 as to the membership and procedure of these Boards.

Regulation 2 makes provision with regard to the terms of office of members of Boards and regulation 3 makes provision for those Boards which must have at least one member who holds a post in a University with a medical or a dental school.

Regulation 4 deals with the remuneration of the members of Boards and regulation 5 with their resignation and removal from office.

Regulation 6 provides for the circumstances in which a person may be disqualified from membership of a Board. Regulation 7 deals with the appointment of a vice-chairperson of committees and sub-committees of Boards.

In Part III there are various provisions with regard to procedure including provisions as to the meetings of the Boards. Regulation 9 makes provision for standing orders regulating the procedure of meetings of Boards and of committees and sub-committees. Regulation 10 makes provision about the appointment and functions of committees. Regulation 11 makes provision with regard to conflict of interest.

Regulation 12 revokes the 1991 Regulations and all amending instruments as mentioned above which provided for membership and procedure of Boards referred to above.

The Schedule sets out the detail of the matters that must be included in the standing orders made pursuant to regulation 9.

SCOTTISH STATUTORY INSTRUMENTS

2001 No. 302

NATIONAL HEALTH SERVICE

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**2 April 2026**
Title:	**Consultant Appointments**
Responsible Executive/Non-Executive:	**A Keen, Director of People & Culture**
Report Author:	**B Salmond, Associate Director of Workforce**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to notify the Board of recent consultant appointments offered by the Chair or their deputy on behalf of NHS Borders Board.

2.2 Background

Board members were briefed in December 2017 on revisions to the NHS Borders guidance on medical consultant appointments. As a result, the Chair of the Board or his/her deputy have delegated authority to offer consultant appointments on behalf of the Board.

2.3 Assessment

Since the last report to the Board, 6 new consultants have been interviewed, offered and accepted a consultant post.

New Consultant	Post	Start Date
Dr Alex Holme	Consultant Dermatologist	April 2026
Dr Maria Khan	Consultant Radiologist	April 2026
Dr Louisa Betram	Consultant Paediatrician	April 2026
Dr Christopher Tee	Consultant Paediatrician	April 2026
Dr Jennifer Brennock	Consultant in Palliative Medicine	April 2026
Dr Catriona Dunlop	Consultant Psychiatrist - MHOAS	June 2026

2.3.1 Quality/ Patient Care

Successful recruitment to substantive consultant posts supports the sustainability of services.

2.3.2 Workforce

Successful recruitment to substantive consultant posts supports the sustainability of services.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed in the preparation of this paper. However Equality and Diversity obligations are fully complied with in the recruitment and selection process.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to note the report.

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

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

- **Significant Assurance (recommended)**
- Moderate Assurance
- Limited Assurance
- No Assurance

3 List of appendices

Not applicable.