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Scottish Borders
Health and Social Care
PARTNERSHIP

A meeting of the **Health & Social Care Integration Joint Board** will be held on **Wednesday, 20th March, 2024** at **10.00 am** via Microsoft Teams

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	Verbal
10.02	**2**	**DECLARATIONS OF INTEREST** Members should declare any financial and non financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.	Chair	Verbal
10.05	**3**	**MINUTE OF PREVIOUS MEETING** 24.01.24	Chair	
10.10	**4**	**MATTERS ARISING** (a) Action Tracker (b) Health and Social Care Partnership Performance and Delivery Report (Copies attached.)	Chair Chief Officer	(Pages 9 - 44)
10.30		**FOR DECISION**		
	5.1	2024/25 IJB Financial Plan and Initial Budget	Interim Chief Financial Officer	(Pages 45 - 54)
	5.2	Hospital at Home	Director of Quality & Improvement	(Pages 55 - 88)
11.30		**FOR DISCUSSION**		
	6.1	Community Hospital Next Steps	General Manager P&CS	(Pages 89 - 98)
	6.2	Director of Public Health Annual Report Update	Director of Public Health	(Pages 99 - 276)
11.55		**FOR NOTING**		
	7.1	Public Protection Report	Rachel Pullman	(Pages 277

				- 294)
	7.2	Strategic Planning Group Minutes: 06.12.23	Board Secretary	(Pages 295 - 306)
11.59	**8**	**ANY OTHER BUSINESS**	Chair	
12.00	**9**	**DATE AND TIME OF NEXT MEETING** Wednesday 15 May 2024 10am to 12pm Scottish Borders Council and via Microsoft Teams	Chair	Verbal

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 24 January 2024** at **10am** via Microsoft Teams

Present:
(v) Cllr D Parker
(v) Cllr T Weatherston
(v) Cllr N Richards
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mrs K Hamilton, Non Executive
(v) Mrs F Sandford, Non Executive
Mr C Myers, Chief Officer
Mr N Istephan, Chief Executive Eildon Housing
Dr L McCallum, Medical Director
Mr P Lerpiniere, Interim Director of Nursing, Midwifery & AHPs
Mrs J Smith, Borders Care Voice
Mrs D Rutherford, Borders Carers Centre
Ms Gwyneth Lennox, Head of Adult Social Work
Mr D Bell, Staff Side, SBC
Dr R Mollart, GP

In Attendance:
Miss I Bishop, Board Secretary
Mr D Robertson, Chief Executive, SBC
Mr R Roberts, Chief Executive, NHS Borders
Mrs J Stacey, Chief Internal Auditor
Mr A Bone, Director of Finance, NHS Borders
Mr P Grieve, Associate Director of Nursing P&CS, NHS Borders
Dr S Bhatti, Director of Public Health
Ms C Oliver, Head of Communications & Engagement, NHS Borders
Ms J Holland, Director of Strategic Commissioning & Partnerships, SBC
Mrs S Errington, Interim Director of Planning & Performance, NHS
Mr B Davies, Head of Strategic Commissioning & Partnerships, SBC
Ms J Glen, Operations Director, Adult Social Care, SBC
Dr A Cotton, Associate Medical Director MH&LD
Mr P McMenamin, Deputy Director of Finance, NHS Borders

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr E Thornton-Nicol, Elected Member, Cllr R Tatler, Elected Member, Mr J McLaren, Non Executive, NHS Borders, Mr T Taylor, Non Executive, NHS Borders, Ms L Gallacher, Borders Carers Centre, Ms J Amaral, Borders Community Action, Mrs J Smyth, Director of Planning & Performance, NHS Borders, Mrs S Horan, Director of Nursing, Midwifery & AHPs, and Ms L Jackson, LGBTQ+.

1.2 The Chair welcomed attendees and members of the public to the meeting including Mrs S Errington, Interim Director of Planning & Performance, Dr A Cotton, Associate Medical Director MH&LD, Ms J Glen, Operations Director, Adult Social Care, SBC, Mr B Davies,

Head of Strategic Commissioning & Partnerships, SBC and Mr P Lerpiniere, Interim Director of Nursing, Midwifery & AHPs.

1.3 The Chair recorded the thanks of the IJB to Mrs Jen Holland for her support to the Board and wished her well in her new role as Chief Executive of Edinburgh Leisure.

1.4 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none declared.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 15 November 2023 were approved.

4. MATTERS ARISING

4.1 **Action 2023-2:** Mr Chris Myers advised that a briefing session would be organised for members for a maximum of one hour.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE AND DELIVERY REPORT

5.1 Mr Chris Myers gave a slide presentation which highlighted some key elements of the report including: CAMHS waiting times; what matters hubs; pharmacy review of social care service users; and increasing carers support plans; finance, workforce capacity challenges; projected outturn for the year at the end of October of just under a £7.4m overspend; Teviot and Liddesdale day services; PCIP demonstrator site; community hospital medical cover; delayed discharges and surge plans;

5.2 Discussion focused on: What Matters Hubs; frequency of hubs; ethos of the hubs; cost benefit analysis; early intervention prevention agenda; key financial pressure areas within health; pressure in adult social care services; learning disability client specific costs; A&E pressures; older people's service revised base budget from £24m to £16m; what was within the gift of the IJB to resolve in regard to surge beds; the health board would be unable to support surge beds moving forward; continue to work on the risk to community hospitals; any data on admissions to hospital due to care at home failing as opposed to admission due to medical reasons; potential to be a pathfinder board in relation to care home admissions and professional to professional discussions to support people to remain at home; and delayed discharges are counted per episode (when fit

on the list and when become unfit due to waiting you are removed from the list until you become fit again) and an analysis is within the delivery report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Performance and Delivery Report, reviewed the performance highlights and exceptions, and overall delivery against Directions.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** supported the standing down of IJB Direction SBIJB-190723-2 on the basis of the successful bid for the PCIP Demonstrator site and the associated funding.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** considered whether any further recommendations should be made at a strategic level in relation to areas highlighted within the report, in order to inform the ongoing prioritisation of the approach of the Health and Social Care Partnership within the remainder of the current financial year, and/or to inform the 24/25 HSCP Delivery Plan and 24/25 Financial Plan.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested to receive an explanation of the line "older people's service revised base budget from £24m to £16m" as detailed within the financial charts.

6. DIRECTION: REPROVISION OF INTERNAL HOME CARE NIGHT SUPPORT SERVICE

6.1 Mrs Jen Holland provided an overview of the content of the paper in regard to the proposal to reduce the night support service from 5 night support teams to 2 rapid response teams. She advised that the service users that were directly involved in the Pathfinders, particularly those in the Peebles area, found it a positive experience with a slightly different picture in the Duns area.

6.2 Mrs Debbie Rutherford highlighted that the Carers Centre had concerns over the consultation especially as only 36% of the 70 responses were in favour of changing the service overall.

6.3 Mrs Jenny Smith also enquired if there was really enough evidence of public support to back the change in service provision. She further enquired about any potential whole system impacts especially in regard to pressure on the Emergency Department at the Borders General Hospital and if the proposal could flex or would be reviewed. It was noted that the concerns highlighted during the consultation and had been mitigated and these mitigations were included in the paper.

6.4 Further discussion focused on: substantial downtime within the existing service; efficacy in the application of the service and the value of a person centred perspective; use of new technology; redeployment of staff; continued engagement with people; mitigation of service users concerns; and correlation of data and how that might impact on the admissions at the Borders General Hospital. As a result of the concerns raised by the carer representative and the third sector member of the IJB, the Chair indicated that it would be helpful to build in a 6 month review of progress in the IJB Audit Committee.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the consultation results.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed the proposal to reduce from 5 Night Support teams to 2 Rapid Response Teams.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted there would be a 6 month review built into the direction for the IJB Audit Committee.

7. REVISED DIRECTIONS POLICY AND PROCEDURE

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the updated Directions Policy and Procedure that was reviewed in the 18 December 2023 IJB Audit Committee.

8. IJB RISK MANAGEMENT POLICY STATEMENT AND RISK MANAGEMENT STRATEGY 2023-2026

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the refreshed IJB Risk Management Policy Statement (Appendix 1) and the updated Risk Management Strategy 2023-2026 (Appendix 2).

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the role and responsibilities of the IJB and IJB Audit Committee within the IJB Risk Management Policy.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the reporting for assurance purposes on the efficacy of risk management arrangements within the IJB Risk Management Policy.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to a discussion on the risk management approach in practice, as set out with the IJB Risk Management Strategy 2023-2026, as part of an IJB Development Session in 2024, which was recommended by the IJB Audit Committee at its meeting on 18 December 2023.

9. 2024/25 INTEGRATION JOINT BOARD FINANCIAL PLANNING PROCESS

9.1 Mr Chris Myers provided an overview of the content of the paper and highlighted: the payment request letter; consequences of the Scottish Budget; potential flat cash settlement that does not cover inflationary costs; and continue to transform services and ensure sustainability.

9.2 The Chair commented that the letter was both transparent and clear in regard to what the IJB were doing and how. She emphasised that it was critical for the IJB as it was the commissioning body that was effectively a funding body to the partners.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** note the final letter sent to the Directors of Finance in NHS Borders and Scottish Borders Council for consideration by their members, and the next steps outlined in the paper.

10. WHOLE SYSTEM CAPACITY OF HEALTH & CARE MODELLING

10.1 Mrs Jen Holland provided an overview of the content of the report and highlighted: reviewing health and social care capacity; pressures across the whole system and unscheduled care flow across the whole system; profile current and future demand needs against current capacity; complexity of need; modelling; format of early intervention and prevention; discharge and referral process; and discharge pathway review.

10.2 Dr Sohail Bhatti suggested in regard to the data that a sensitivity analysis be included. He further suggested that if service and need was delayed by 6 or 12 months it would have a significant impact and might assist in working out how to stop the tumult of demand that was being serviced with less resource. He suggested the modelling should work out what the impacts might be and enable targeting of groups or the population at the right time. Mrs Holland supported Dr Bhatti's suggestion and advised that it was within the scope.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the work that will be commissioned by the Health and Social Care Partnership.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** provided comments on the approach being undertaken to inform the commission.

11. MENTAL HEALTH AND LEARNING DISABILITIES MEDICAL WORKFORCE SUSTAINABILITY

11.1 Mr Chris Myers introduced the item and advised that he felt it important for the Board to be cited on the risk that sat within the mental health medical workforce and across the wider mental health service and to understand the context that the service were working in from a medical perspective.

11.2 Dr Amanda Cotton provided an overview of the content of the report and advised that it set out a strategic approach to the development of medical staffing and how to grow the middle grade tier into our own autonomous and expert doctors to a new senior level.

11.3 Dr Lynn McCallum commented that the lack of consultant psychiatrists was a national issue and locally NHS Borders had been fortunate to recruit 2 consultants however there would still be gaps in the service which the plan would help to mitigate against. She formally recorded her thanks to Dr Cotton for the work she had put into keeping the service safe and able to deliver effective patient care to the people of the Borders.

11.4 Further discussion focused on: creative solution; over medicalising; delivery of services in line with the Mental Health Act; conflation of the mental health and wellbeing agenda; capable communities, society and primary care services; diagnosis and medication; society refer to mental health services as it validates their mental health problem; overall

affordability and cost effectiveness; mitigation of risk on workforce performance and safety; and removal of barriers to achieving greater efficiencies.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

12. SCOTTISH BORDERS MACMILLAN IMPROVING THE CANCER JOURNEY

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

13. AUDIT COMMITTEE MINUTES: 19.06.23

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

14. STRATEGIC PLANNING GROUP MINUTES: 01.11.23

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

15. ANY OTHER BUSINESS

15.1 **Commissioning of OD work:** The Chair advised that some OD work would be commissioned to assist in building the IJB as a Team.

15.2 **Reissue of IJB Handbook:** The Chair advised that the revised IJB Members Handbook would be issued to IJB members.

15.3 **Joint Staff Forum:** Mr Chris Myers advised that the Joint Staff Forum would be holding a workshop to look at how to progress the integration agenda and joint working.

15.4 **Employability Partnership:** Mrs Jenny Smith advised that Mrs Juliana Amaral was keen to have an update on the funding agreed in 2023 for an NHS employee to work within the mental health service on employability as the third sector were looking to bring in employability working and wanted it to be complimentary. Mr Chris Myers advised that he would feedback to Mrs Amaral.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the updates.

16. DATE AND TIME OF NEXT MEETING

16.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 20 March 2024, from 10am to 12 noon through MS Teams and in person in the Council Chamber, Scottish Borders Council.

SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

ACTION TRACKER

Scottish Borders Health and Social Care PARTNERSHIP

Meeting held 15 November 2023

Agenda Item: H&SCP DELIVERY REPORT

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2023-2	5	The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that Mr Myers would produce a briefing note for members on the on-going digital work.	Chris Myers	February 2024	A Member's briefing is being arranged to update IJB members in April.	R

Meeting held 24 January 2024

Agenda Item: HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE AND DELIVERY REPORT

Action Number	Reference in Minutes	Action	Action by:	Timescale	Progress	RAG Status
2024-1	5	The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested to receive an explanation of the line "older people's service revised base budget from £24m to £16m" as detailed within the financial charts.	Chris Myers	March 2024	**Complete:** Response emailed, clarifying that this related to the Scottish Government allocation for social care which is allocated to Health Boards that is then transferred to the Scottish Borders Council.	G

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

Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 March 2024

Health and Social Care Partnership Performance and Delivery Report

Report by Chris Myers, Chief Officer

1. PURPOSE AND SUMMARY

1.1. The Integration Joint Board are asked to note the overview of the Health and Social Care Partnership delivery against its Strategic Framework and Annual Delivery Plan, and against the implementation of approved directions.

1.2. This report is intended to give Integration Joint Board members, and members of the public an overview of some of the progress being made in the Scottish Borders to provide more seamless care, and deliver against our Health and Social Care Strategic Framework 2023-26 and associated Annual Delivery Plan. Appendix 1 provides an overview of performance and Appendix 2 provides an overview of progress against the delivery of directions.

1.3. There continues to be positive progress developing the carer strategy and implementation plan, along with steps taken to increase supports with additional bed based respite, the day support pathfinder in Newcastleton, and the new day service in Hawick being close to opening. Work to review day supports in Eildon is ongoing and has provided much valuable information about the constraints and opportunities in the area.

1.4. Our What Matters Hubs continue to expand in function and location, including Young Persons Hubs continuing to develop in High Schools.

1.5. High levels of Self Directed Support and continued increases in homecare capacity show our collective success in this area. However, despite 12% extra homecare and Self Directed Support hours being brought into place between April 2022 and January 2024, this has accommodated a 2% increase in the number of service users. This reflects the growing levels of need from amongst our communities. This has also been experienced in rising acuity and medical length of stay in hospital, and the increase in demand for care from the hospital system.

1.6. In line with this, despite the £1.9m delayed discharge plan commissioned by the Integration Joint Board, and levels of transfers to care / HSCP services being in line with our forecasts, this has been offset by significant levels of additional demand which has been 16.1 per week and 26% higher than our forecast demand of 12.8 per week and based on the actual demand over the preceding 26 week period before the trajectory was put into place:

1.6.1. Had demand been in level with forecast, then in the week commencing 11 March, based solely on current transfers to HSCP services, we would have been one above trajectory with a total of 30 delayed discharges (compared to the actual of 71). Based on both current transfers to HSCP services and the current level of removals due to ill health, there would be 0 delayed discharges.

1.6.2. Had we not had the additional removals associated to the surge plan, based on actual demand there would have been 194 people delayed and waiting for care in the week commencing 11 March (compared to 71). As a result, despite performance being above trajectory due to demand, it is worth noting that the IJB £1.9m delayed discharge plan has had a significant impact and brought us 123 less people being delayed discharges to date, and longer term additionality in terms of investments into care. We have also seen high levels of people discharged without delay (96.5% in the latest data (4 March)).

1.7. At this stage it is unclear as to whether demand will continue to remain at this high level, reduce or continue to grow.

1.8. Further actions are planned (e.g. development of reablement in homecare, social work digital pathfinder), and work has commenced to try to model out future trajectory scenarios, but in common with the position last year, we will not be able to confirm additional actions and the trajectory until we have received both payment offers and are in a position to agree the IJB budget for 24/25.

1.9. Appropriate supports and ongoing transformation for increased productivity / capacity in health and social care, with increased focus on preventative measures such as Community Led Support and services that promote Wellbeing, the ongoing development of carer respite, along with Hospital at Home/ virtual ward will clearly need to be key planning considerations for the financial plan and HSCP delivery plan for 2024/25, and beyond. The work agreed by the last IJB to commission whole system capacity of health and care modelling will be key to the IJB's planning over the longer term. All of this work will need to occur against the very challenging financial and workforce constraints we face, and increase the requirement for transformation, savings and integration.

1.10. Overall, good progress is being made in relation to the implementation of the directions issued. 6 are complete, 12 are progressing to plan, 1 is delayed, and 3 areas have been highlighted as having significant delivery challenges. Of the remaining 3 with significant delivery challenges:

- The first relates to the overall financial position for the Health and Social Care Partnership, including the financial overspend on delegated and set aside services in health services, which is being regularly reviewed by the IJB and the IJB Audit Committee jointly with both Finance teams across the Health and Social Care Partnership.
- The second relates to the integration of Home First with Adult Social Care. There have been delays involved in this complex transformation project associated to the need to ensure appropriate staff governance, consider differences in pay terms and conditions, and current service overspend. A paper will be developed for the Joint Executive Team in the first instance in order to determine the next steps.
- The third relates to the Delayed Discharge and Surge Plan which unfortunately has not been fully realised as detailed above and in Appendix 1 Performance report.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) Note the contents of the Health and Social Care Partnership Delivery Report.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
x	x	x	x	x	x

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x	x	x	x	x	x

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required.

5. BACKGROUND

5.1. This is a monitoring report to support the effective functioning and performance oversight of the IJB, and the implementation of our strategic objectives.

5.2. This report is intended to increase awareness for IJB Members and the public on the breadth of work and added value that is being undertaken by the Health and Social Care Partnership to deliver against our Strategic Framework, develop integration locally, and improve outcomes.

6. HIGHLIGHTS RELATING TO INTEGRATION WORKSTREAMS WITHIN THE ANNUAL DELIVERY PLAN

<u>Care Village update – Tweedbank and Hawick</u>

6.1. Tweedbank will have 60 beds for Intermediate, long stay residential, respite and dementia care. A needs assessment is ongoing as part of the development of the Full Business Case for the Hawick Care Village to determine the requirements in Hawick. This considers the interface and impacts of the proposed Extra Care Housing in the area that will be developed by Eildon Housing Association on the Stirches site.

6.2. There is close working across the HSCP on the model of care requirements and dementia design. There is partnership working with the voluntary sector and Stirling University (Dementia Services Development Centre). There is also partnership working with Eildon for the Hawick development. Partnership working will increase as the project progresses to include Borders College, Borders Social Enterprise, Voluntary groups and others as required.

Tackling Health Inequalities in the Scottish Borders

6.3. The THIS Borders Strategy (Tackling Health Inequalities in the Scottish Borders) is currently in development and it is anticipated that it will be published in Spring 2024. A thorough data analysis has been undertaken and work is underway to develop metrics to support review of our progress following the production of the strategy. We have engaged with a range of staff groups across the Health and Social Care Partnership and beyond, and we have plans to engage more widely with third sector partners to understand the how we can work together to address the wider determinants of health. Through consultation with members of the Community Planning Partnership (CPP) we have agreed to create a delivery group for taking forward actions arising from the recommendations in the strategy. The delivery group will bring together CPP partners across a wide range of sectors to consider how we can have collective impact in promoting prevention and early intervention.

What Matters Hubs / Community Led Support

6.4. Currently we are running Galashiels (Tuesday), Peebles and Kelso (Wednesday) and Hawick (Thursday) 'What Matters Hubs' weekly from 10am – 3pm. Duns and Eyemouth run on alternate Tuesdays but in March, this changes to weekly. There is third sector support at the hubs from Social Security Scotland, Alzheimer's Scotland, Telecare, Local Area Co-ordination, Sustainable Selkirk, Red Cross, BCASS, CAB and Borders Carers Centre.

6.5. In Kelso on the 21 February 2024 we launched a Mental Health Information Station which will run monthly and will be hopefully rolled out to all the hubs. We also are launching a Young Persons Hub within Hawick High School on 28/2/24 and this will run weekly over a lunch time from 1-15 – 2.15 and will be themed to include young carers, keep safe, careers, local clubs and supports. This will replicate the Young Person's hub which runs at Peebles High School each Thursday lunchtime.

Partnership with Home Energy Scotland

6.6. From October to December 2023, Home Energy Scotland worked in partnership with Scottish Borders Health and Social Care Partnership to delivery energy advice in person to patients attending vaccination clinics across the Scottish Borders. Home Energy Scotland (HES) is a free and impartial service funded by Scottish Government and managed by the Energy Saving Trust. The service provides advice on energy efficiency, renewable technology, sustainable transport and water advice aimed at keeping people warm, helping them to save money and reducing carbon emissions. As well as a range of practical advice, HES identify households who are eligible for Warmer Home Scotland which is focussed on improvements to energy efficiency in the home. The value of improvements available to households can be up to £10,000 with a wide range of insulation and heating improvements provided subject to a personal survey of the property.

6.7. The team engaged with 1074 people over a three month period in 8 locations at Galashiels, Peebles, Kelso, Lauder, Newton, Duns, West Linton and Selkirk. The demographics of the vaccination cohorts commencing with at-risk groups followed by older members of the community means that energy advice and keeping warm are very relevant and useful messages to receive.

6.8. The people engaged with received bespoke advice in person, a resource to take home with contact information. Around 10% of people agreed to more in-depth follow up with a phone call from an advisor where further help such as referrals to Warmer Home Scotland can be explored and a number of households have received this help with a range of very successful outcomes benefiting health and wellbeing.

Development of a Health and Social Care Partnership Carers Plan/Strategy

6.9. The work on a Carers Strategy and Implementation Plan continues to progress, the plan being co-produced alongside Carers and members of the workstream. The draft strategy's vision is: "Carers will be supported to easily access flexible support, advice and information to best meet their outcomes and those of the person they look after." The Borders Carers Centre and Chimes are commissioned to undertake work on Carers and Young Carer support plans, assessments and reviews of Replacement Care being carried out by the Scottish Borders Council Community Care Reviewing Team.

6.10. Following the update in January 2024, further consultation is ongoing with aim of completing the Integrated Impact Assessment in relation to the Carers Plan/Strategy. The target date for completion of the Integrated Impact Assessment is April 2024, and then to submit the paper to the IJB for approval.

Supporting unpaid carers to get breaks from caring

6.11. As previously stated, to November 2023, 207 Carers were in receipt of a Carers Act budget to support their right to a break from their caring role, an updated figure having been requested at the time of writing. Four high dependency respite rooms are envisaged, one currently being available for respite through the independent sector.

6.12. Our pathfinder in Newcastleton to provide day supports for people including those with personal care needs by bolstering existing community supports with the provision of home care is ongoing in the Buccleuch Warm and Well. We have had good feedback to date and plan to evaluate this shortly.

6.13. In relation to the new Hawick Day Service, the Care Inspectorate has allocated an Inspector to support the onward registration process of the new service. The Inspectorate have indicated that an April completion date for the registration may be possible. Based on this information, we will aim to get this new service based in Hawick Community Hospital up and running promptly after we receive registration. Decoration and flooring of the main day service area and corridor is completed. The shower area is still outstanding but will not delay opening of the service. Staffing and recruitment is complete.

6.14. A visit to the Hawick Community Hospital setting was made on 29 February by members of the Teviot and Liddesdale Task and Finish Group, the Teviot Day Service Support Group and the Care Inspectorate where they received an update on progress. All that attended were pleased to see the improvements that had been made and the environment that had been created, stating that these exceeded their expectations.

6.15. We will support a launch event once the service is ready to open which will be an opportunity to ensure that relevant community stakeholders are kept appraised and where possible are able to be involved with the service. Integration Joint Board members will be invited to this event.

6.16. Research is ongoing to identify need and options for day supports in Eildon via the Eildon Day Supports Task and Finish Group is underway. As part of this we have liaised with a range of community groups, individuals and staff through in person meetings and via surveys.

Local Area Coordination Review

6.17. The review is now complete and the recommendations are currently being considered engaged on with staff. The review recommendations include a reset of the service to ensure it meets the objectives of a Local Area Coordination model generating opportunities within localities and

neighbourhoods for participation in activities and areas of interest for those who meet social care criteria. A period of consultation will now take place with staff and our communities as part of our Integrated Impact Assessment process. The consultation period will take in the region of 3 months to complete, and a paper will come back to the IJB with the final recommendations.

Physical Disability Strategy

6.5 The Physical Disability Strategy group have been working with people with Physical disabilities and long term conditions. They have met groups of users carers and interested parties 8 times over the past year. The strategy, its key ambitions and action plan have been coproduced and reflect the aspirations and challenges experienced by people with a physical disability living in the Scottish Borders.

6.6 The next phase will involve carrying out an Integrated Impact Assessment where a range of other groups of people with relevant protected characteristics will a engaged in the strategy development.

6.7 The development meetings have been attended by 17 Ability Borders members attended all of whom have either a long-term health condition or physical disability, 4 family carers and representatives from; Scottish Borders Council, Occupational Health, Housing, NHS Borders, Joint Health Improvement Team, Borders Older People's Forum, Dynamic Community Fusion, Hawick Acorn Project Initiative, HCC Reaching Out Scottish Borders, Scottish Borders Carer's Centre Spinal Injuries Scotland and Wildsmith Training.

7. IMPACTS

Community Health and Wellbeing Outcomes

7.1. The intention of this report is to provide a focus for improvement of health services therefore should indirectly impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Increase
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increase
5	Health and social care services contribute to reducing health inequalities.	Increase
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	Increase
7	People who use health and social care services are safe from harm.	Increase
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

Financial impacts

7.2. There are no costs directly associated with this report. Indicative costs to implement directions are highlighted where known. The Strategic Plan and Financial Plan directions set out the overall expected costs for the IJB.

Equality, Human Rights and Fairer Scotland Duty

7.3. An assessment against these duties is not required as this is a summary report and IIAs will be conducted as required for each item.

Legislative considerations

7.4. All relevant legislative considerations are included in each of the relevant IJB reports.

Climate Change and Sustainability

7.5. All relevant climate change and sustainability considerations are included in each of the relevant IJB reports.

Risk and Mitigations

7.6. All relevant risk considerations are included in each of the relevant IJB reports.

8. CONSULTATION

Communities consulted

8.1. Details of communities consulted are included in each of the relevant IJB reports.

Integration Joint Board Officers consulted

8.2. Not relevant.

Approved by: Chris Myers, Chief Officer

Author: Various

Background Papers: Not applicable

Previous Minute Reference: Not applicable

For more information on this report, contact us at:
Chris Myers, Chief Officer at chris.myers@scotborders.gov.uk

Appendix 1: Performance Report

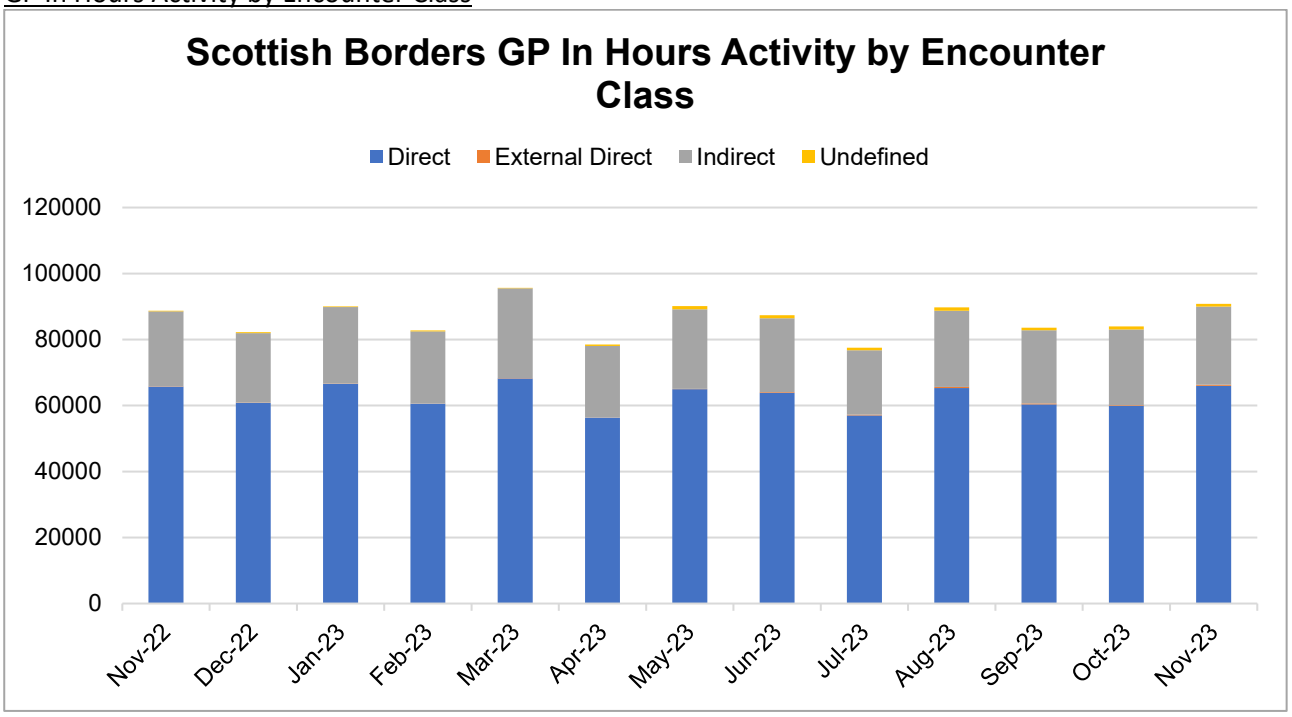
Scottish Borders
Health and Social Care
PARTNERSHIP

Performance Report (including Quarterly Performance Report) for the Scottish Borders Integration Joint Board March 2024

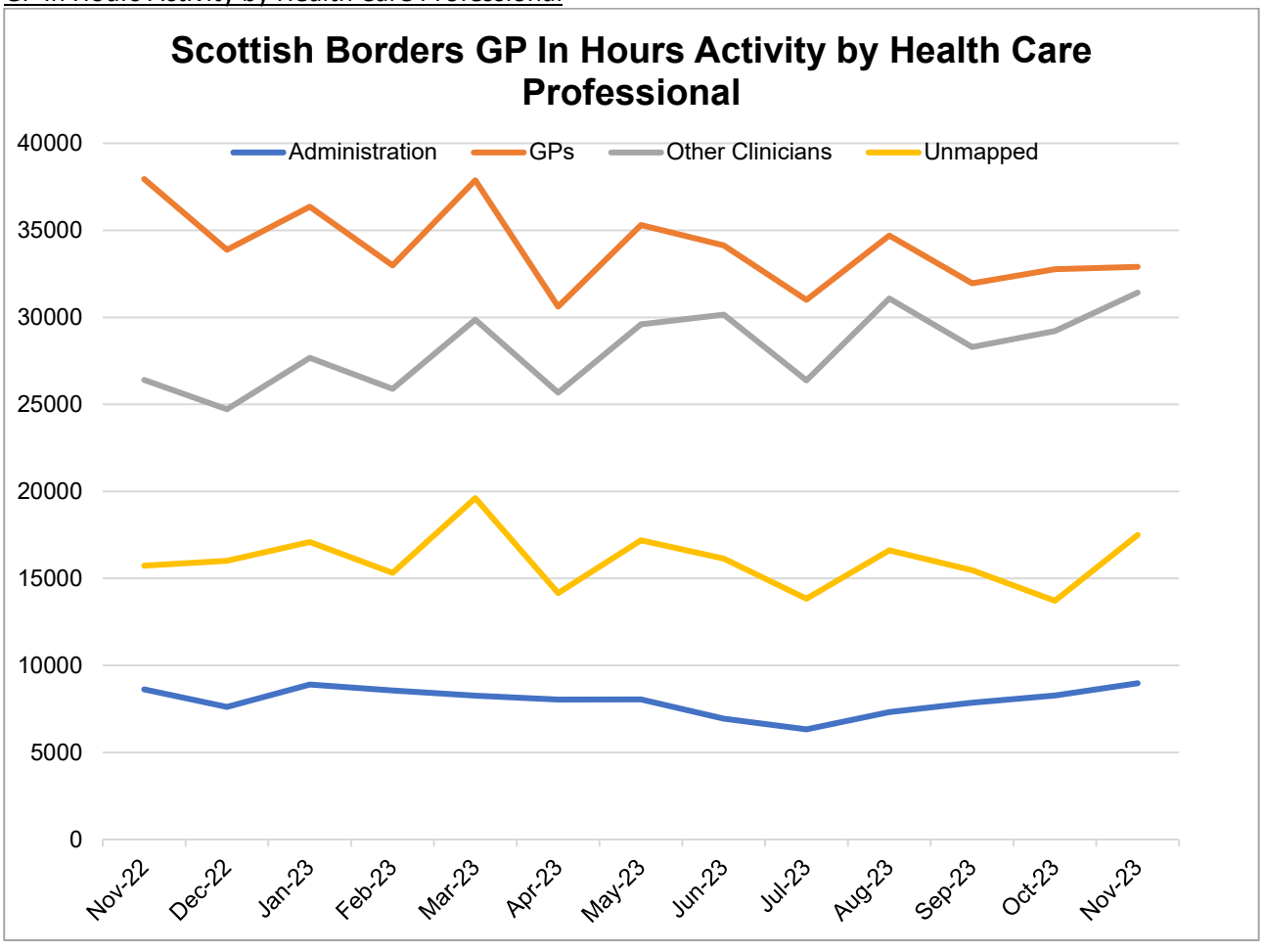
SUMMARY OF PERFORMANCE:
Latest available Data

Objective 1: Improving Access

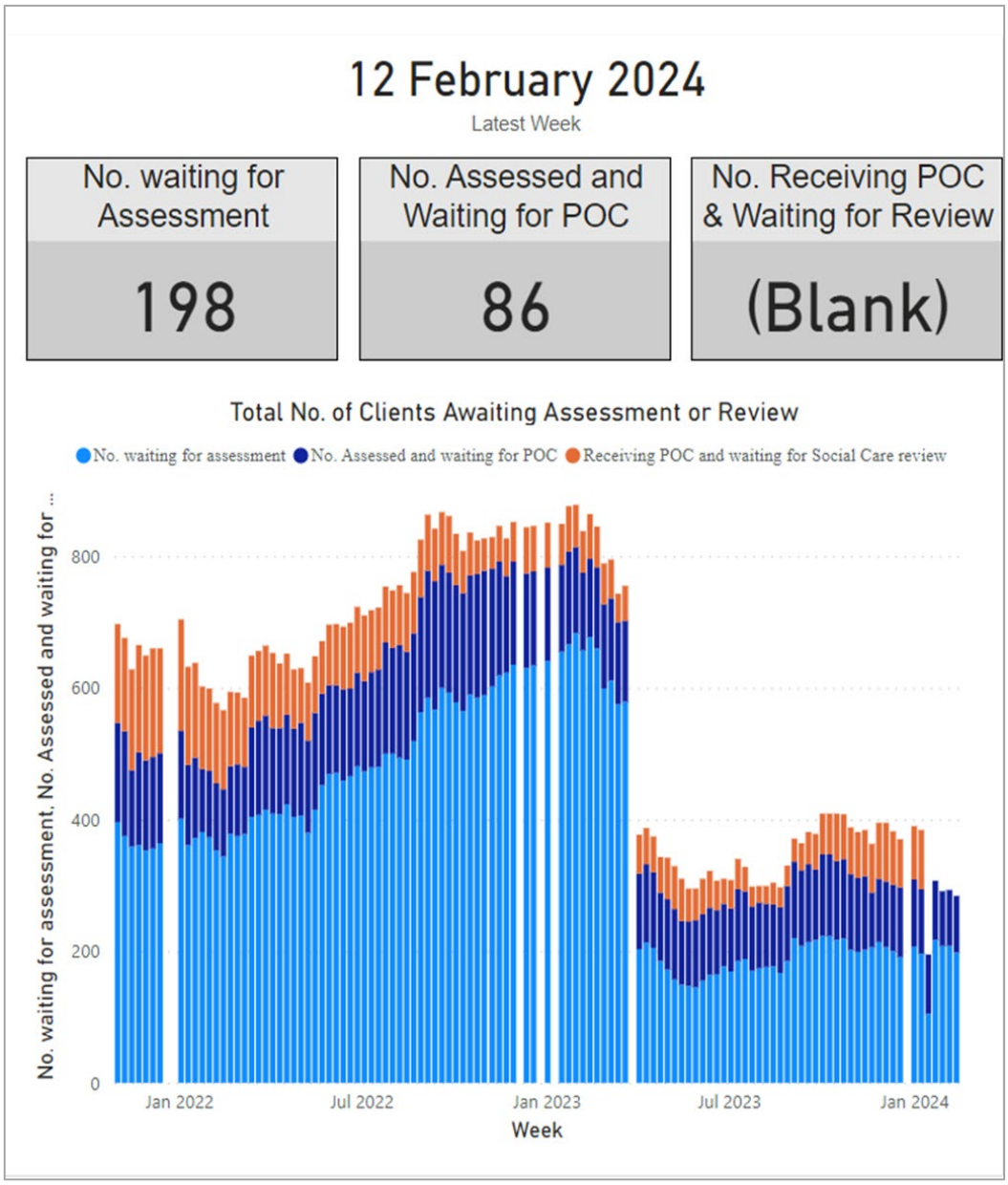
GP In Hours Activity by Encounter Class



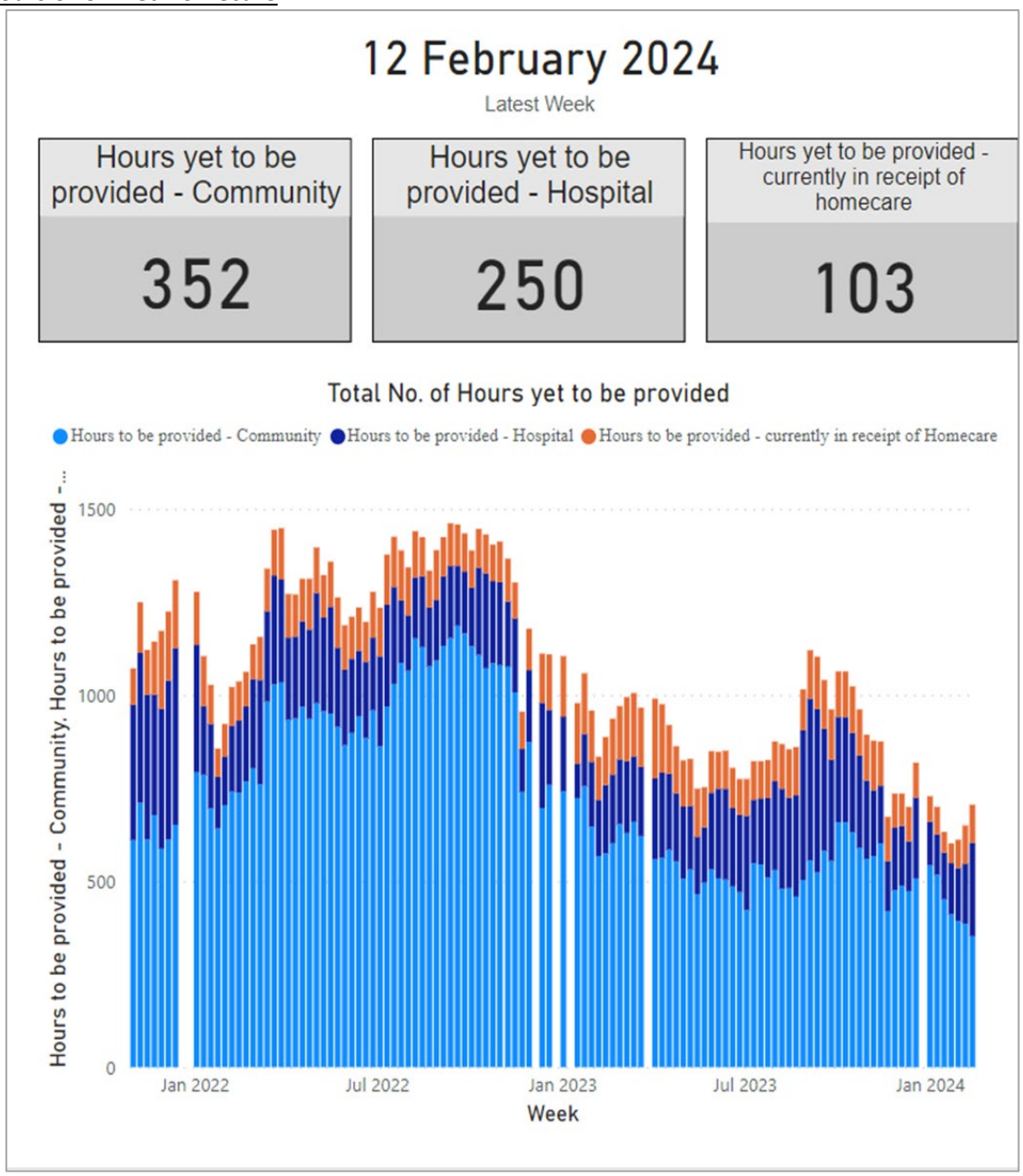
GP In Hours Activity by Health Care Professional



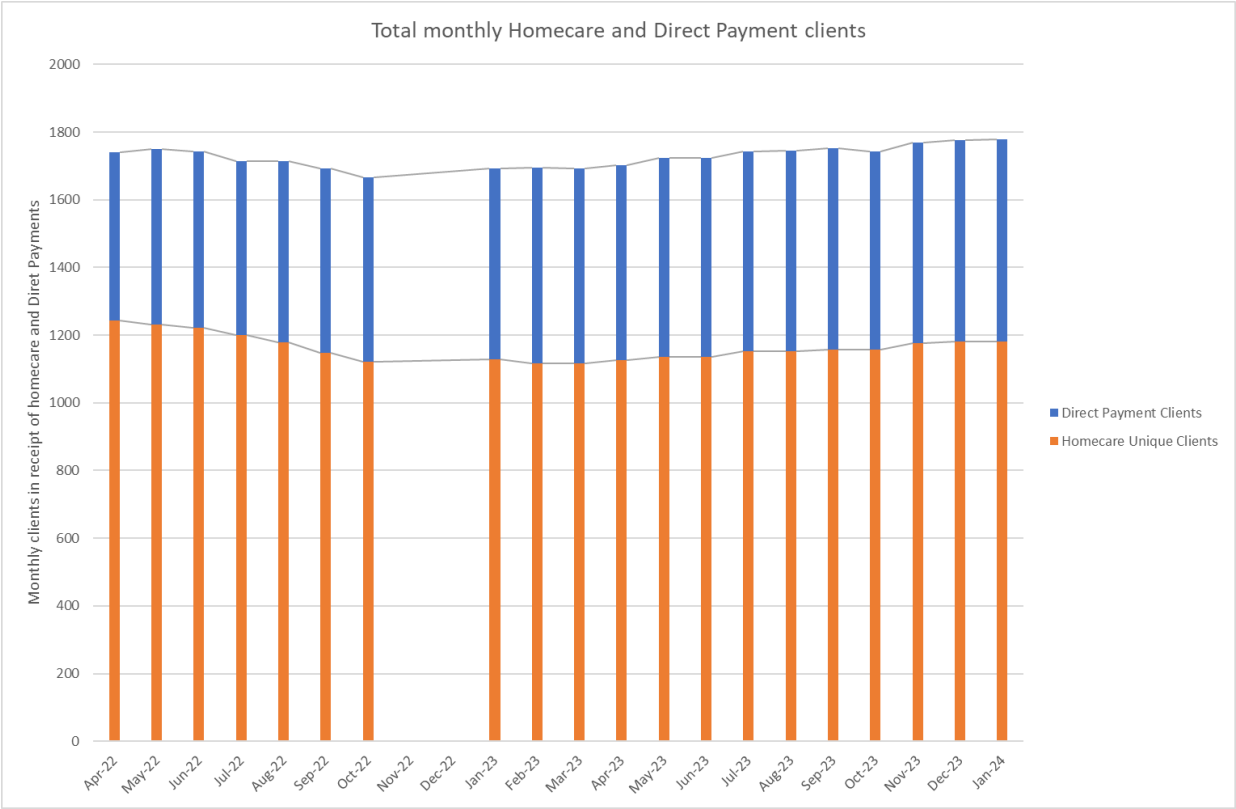
Social Work Assessment Waiting List

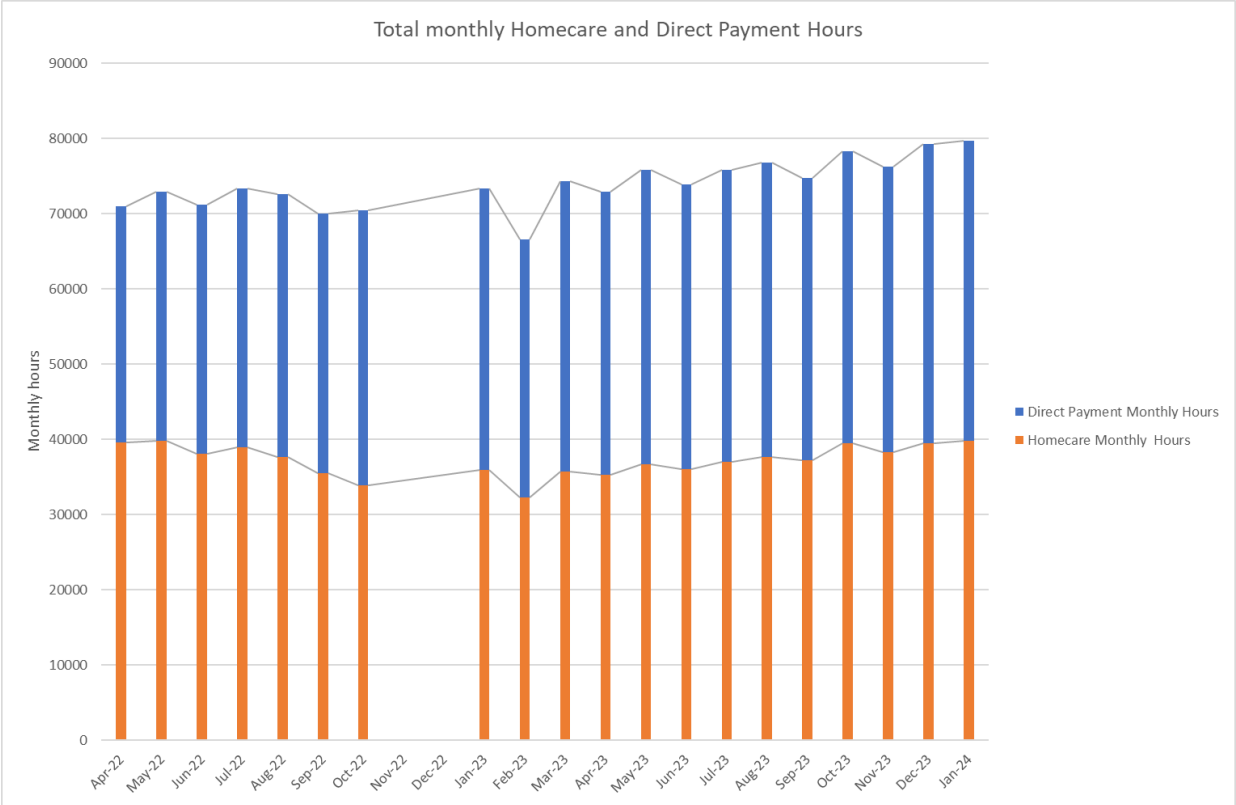


Total Hours of Unmet Homecare



Homecare and Direct Payment clients and monthly hours

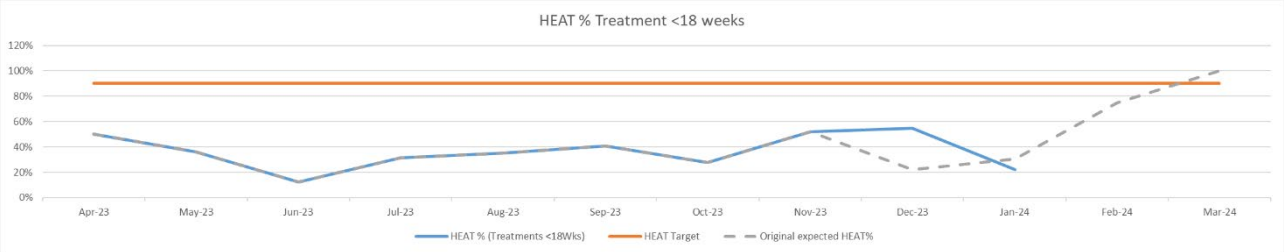




*'Homecare' includes internal and external homecare, housing with care and Extra Care Housing.

Despite 12% extra homecare and Self Directed Support hours being brought into place between April 2022 and January 2024, this has accommodated a 2% increase in the number of service users. This reflects the growing levels of need from amongst our communities.

Child and Adolescent Mental Health Waiting Times



What is the data telling us?
The table shows the current trajectory based on the current projected accepted referrals and number of treatments to be completed (12 New Patient Appointments per week 51 per month) which is currently being weighted in favour of 70% Cat 2 and 30% Cat 1 in order to meet the LDP (Heat target) earlier than originally reported.

Patients Seen - Performance (0-18 weeks) for January 2024 has decreased to 22.2% compared to data for last month (54.5%). The number of patients being seen has increased (27) compared to 11 for December 2023. 0 patients have been seen in the over 35-week cohort as there are no patients waiting in this cohort.

Patients Waiting - The total number of patients waiting as at end of January 2024 has decreased (78) compared to 105 as at end of December 2023.
There has been a decrease in patients waiting over 18 weeks for treatment: 26 patients for January 2024, compared to 41 for December 2023.

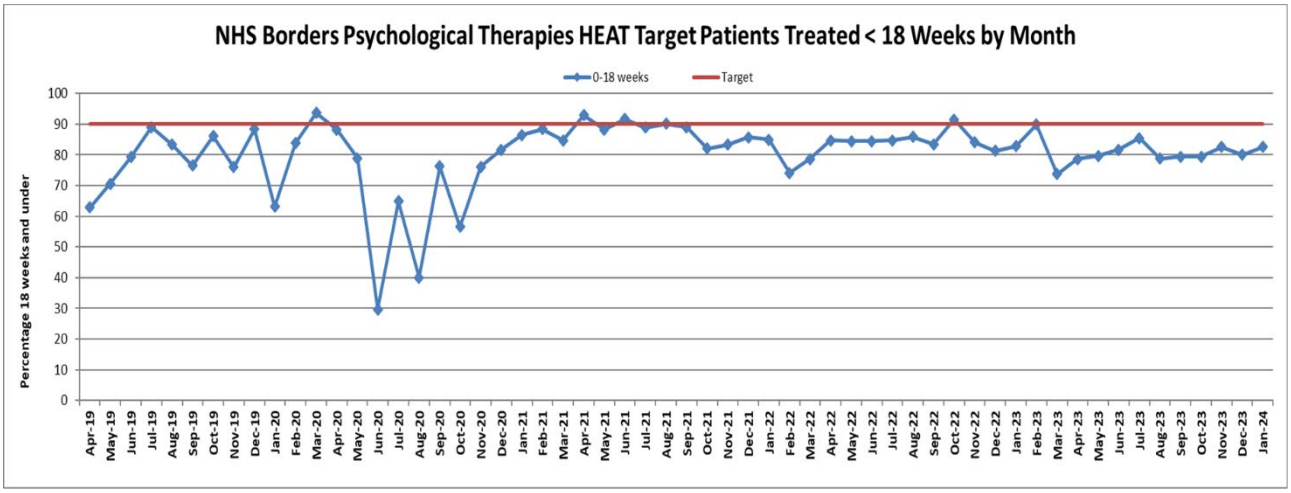
Patients Waiting Queue Shape - The longest wait for treatment yet to commence is unadjusted 38 weeks (this is reduced to 8 weeks with adjustment for DNA) as at the end of January 2024, this patient has been seen for treatment in February 2024.

DNA - For January 2024 there were 3 DNAs for a first patient appointment, this is an increase from 1 for December 2023. However, first contact appointments have increased for January 2024 with 28 patients being seen for a first contact compared to 11 in December 2023. Therefore, the percentage DNAs for a first patient appointment has increased only slightly to 9.7% for January 2024 compared to 8.3% for December 2023.

Referrals - There has been a decrease in the total number of referrals for January 2024 (41) compared to 44 for December 2023.
There has been an increase (+1) in the number of rejected referrals for January 2024 (28) compared to 27 for December 2023. The percentage rejected has therefore increased for January 2024 (68.3%) compared to December 2023 (61.4%).

Open Caseload - Caseload has decreased by 31 to 547 for January 2024.

Psychological Therapies



Current activity and performance against HEAT Target

The 18 week RTT HEAT target for Psychological Therapies measures those people who are starting treatment and how long they have waited for this to start.The target is to see 90% of those starting treatment within 18 weeks.

Performance this month towards the PT RTT standard is slightly down from last month at 80% - last months was 82.61%. In December the service started treatment with 120 patients (184 in November 2023) of which 24 (32 in November 2023) patients had waited longer than 18 weeks for a first treatment appointment (Figure 1).

Our LD psychology service is under great pressure with a known capacity gap. Older adult psychology is also under great pressure due to vacancies and this situation is not likely to improve in the next six months. CAMHS Psychology is also under pressure due to maternity leave. Adult mental health secondary care is under great pressure due to unprecedented and sustained high referrals and vacancies.

Current PT Waiting List

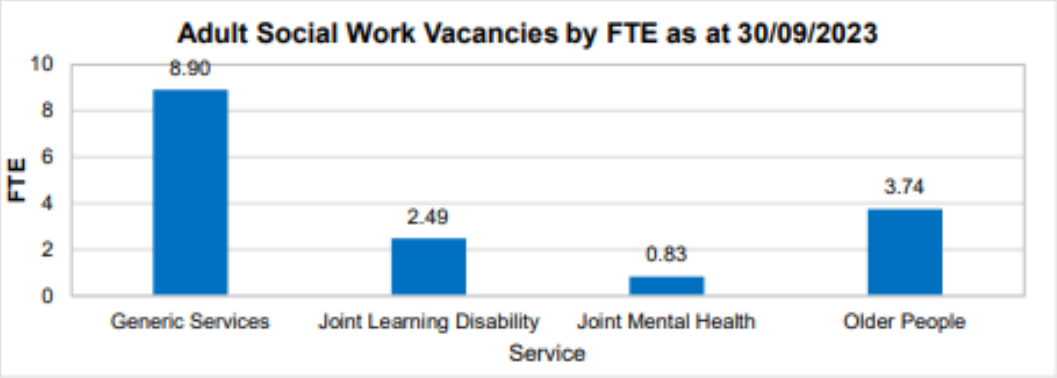
As at 31st December 2023 we have 640 people on our waiting list, a slight increase of 2 from last month, 88.1% of whom have waited less than 18 weeks. We do not have anyone waiting over 52 weeks. We have 7 people waiting in the 35-52 week range which represent 1.1% of those waiting. Waits over 18 weeks are mainly due to capacity issues and delays in secondary care psychology services, especially older adults, learning disability, substance misuse and adult mental health. For those areas which have had an increase in referrals, we are noticing a build-up of assessments, which will most likely impact on treatment waits.

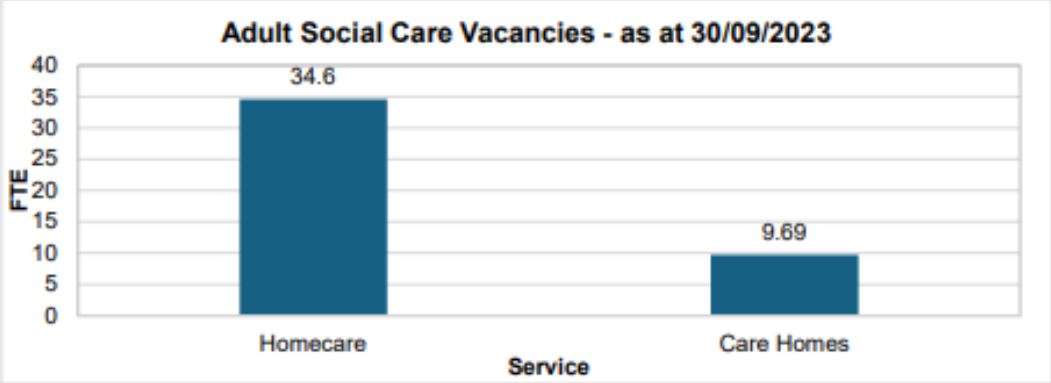
Workforce

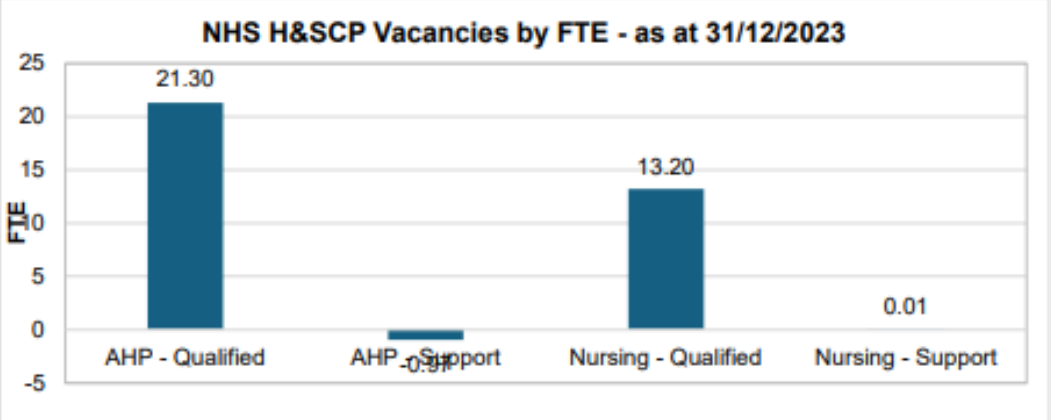
We have some current vacancies and gaps in service that are impacting on our performance. Current vacancies are in adult and older adults psychology. We continue to try to recruit to these posts and are using some locums where possible. We have three members of staff on maternity leave in child psychology/CAMHS.

Objective 2. Rising to the workforce challenge

Vacancies by FTE

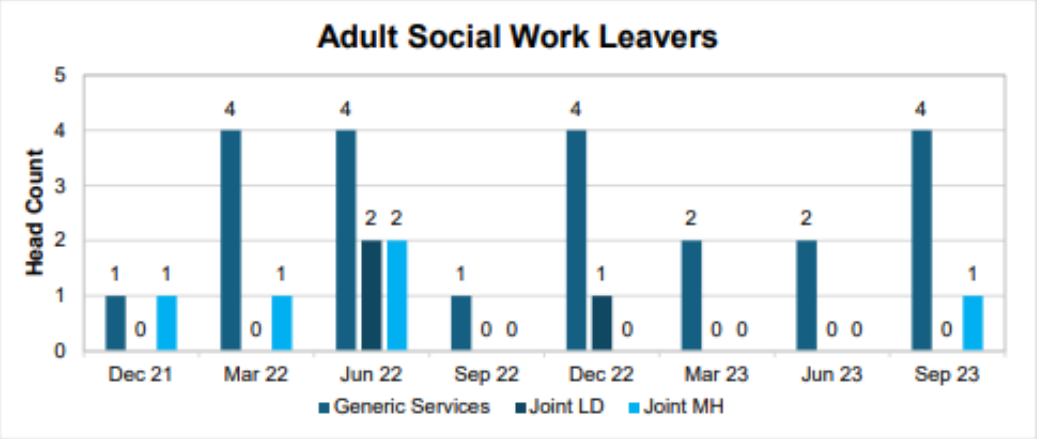


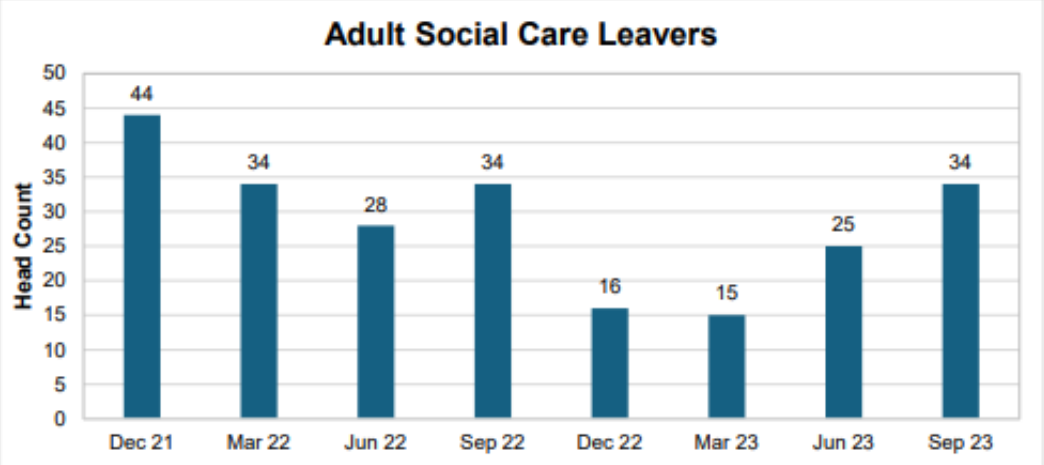


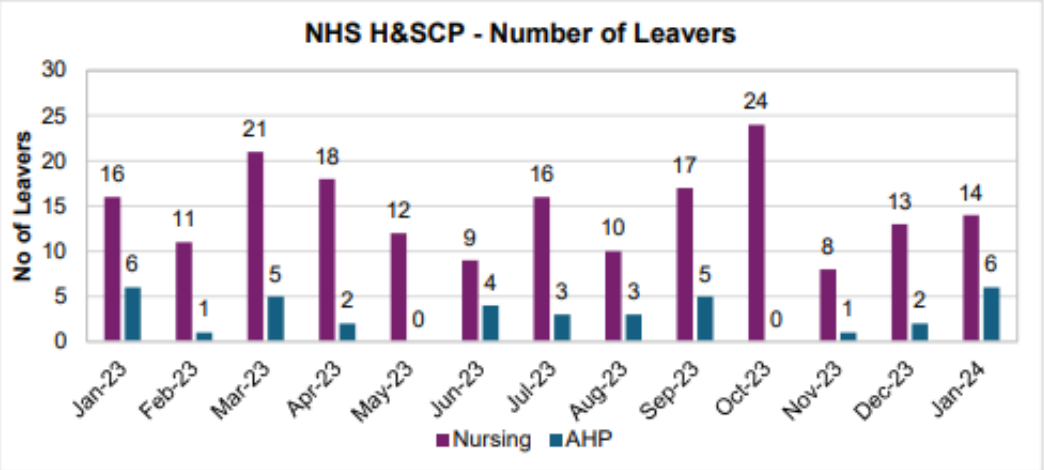


Leavers

Source: HR, SBC

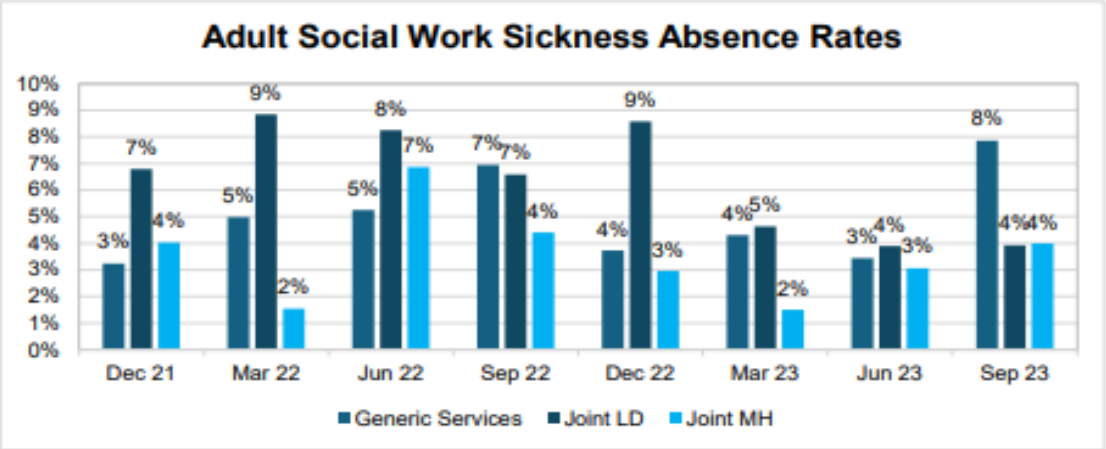


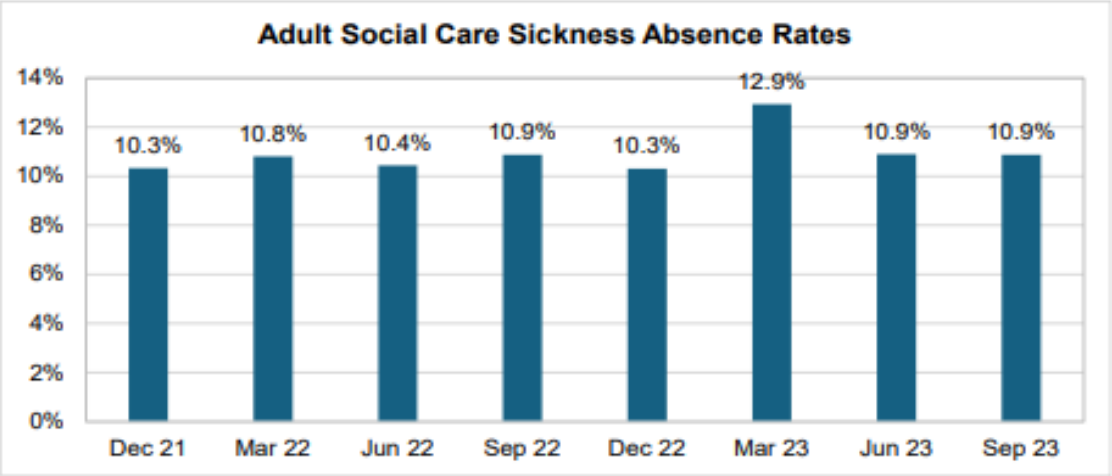


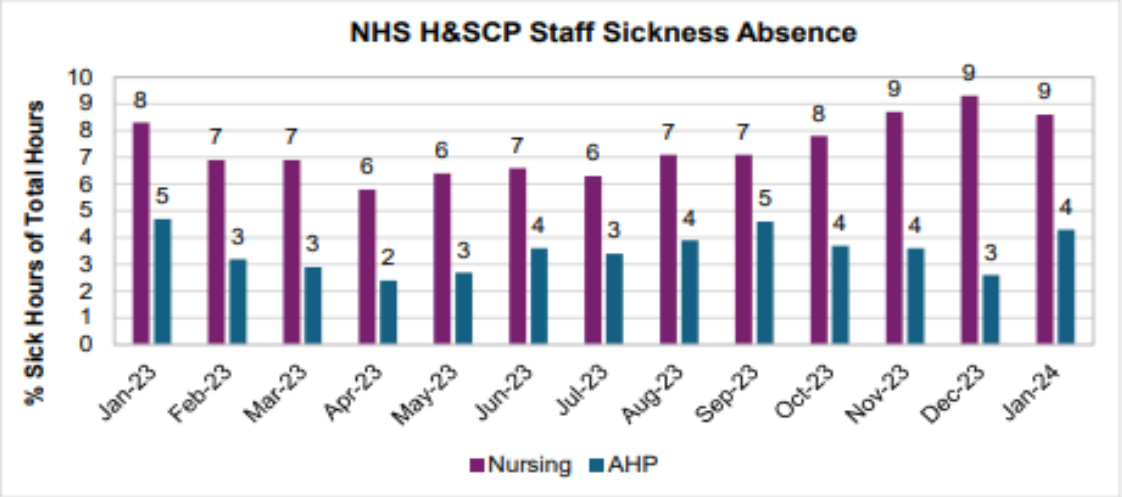


Sickness Absence Rates

Source: HR, SBC

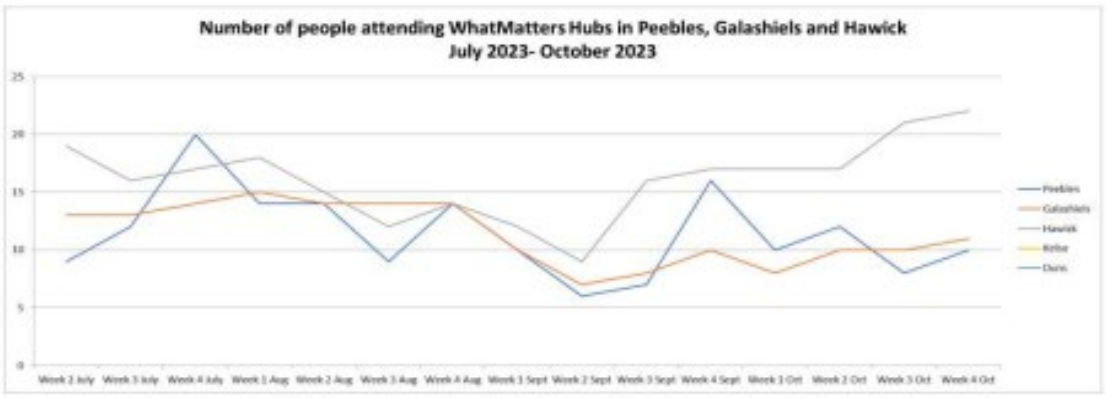


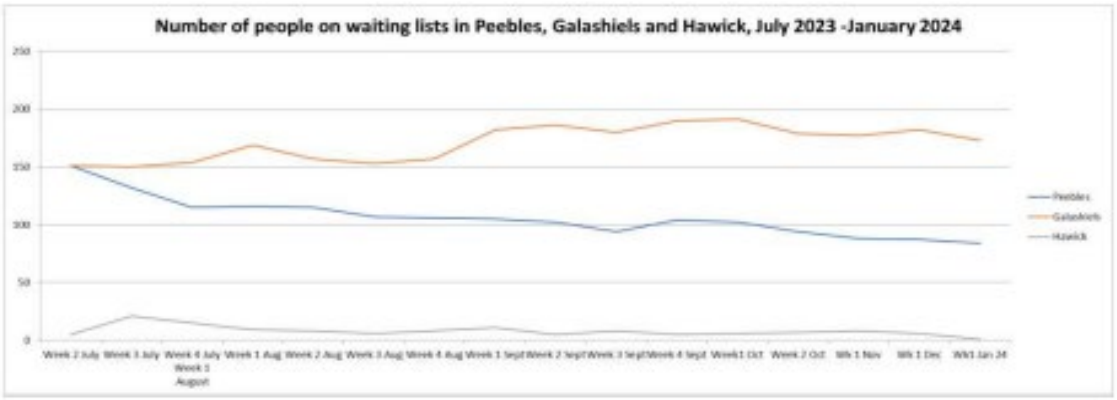


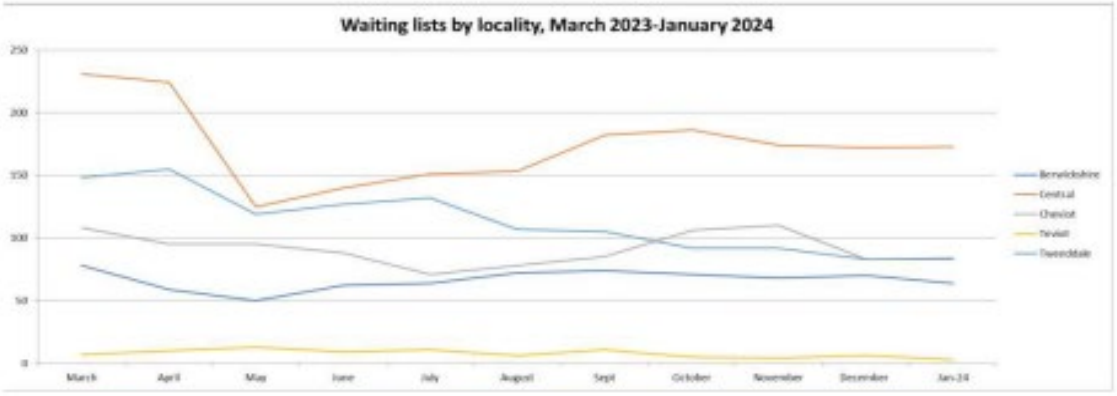


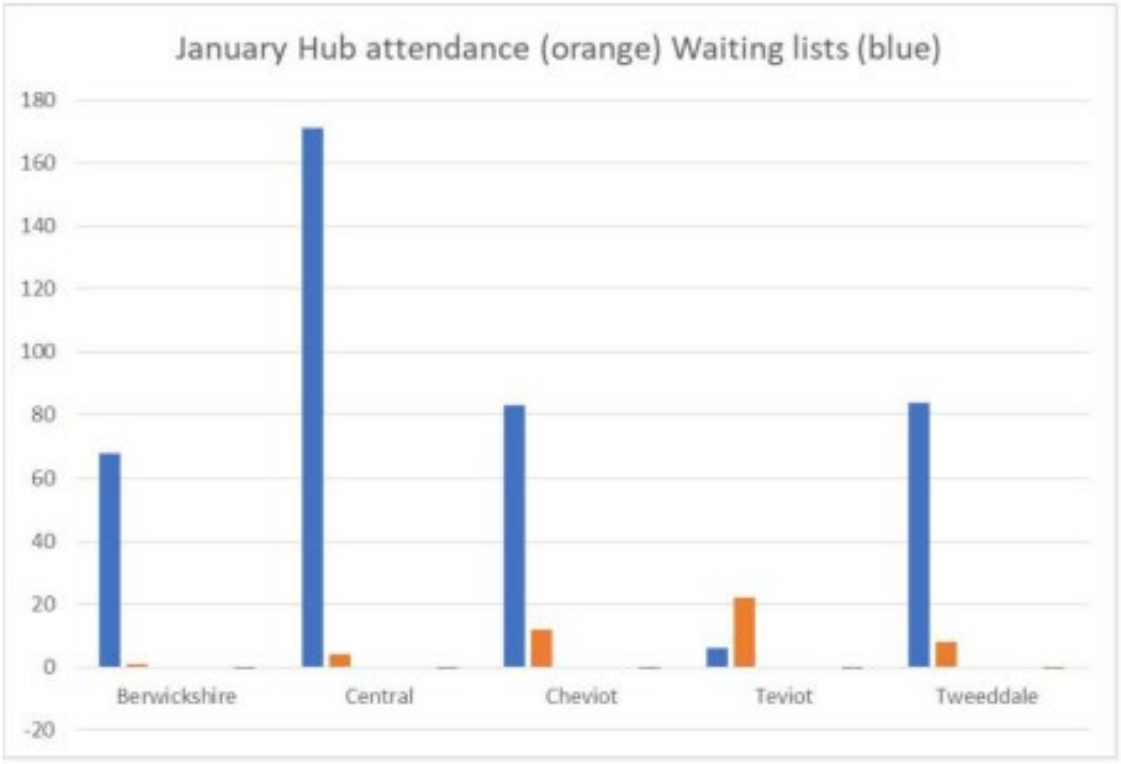
Objective 3. Prevention and early intervention

WhatMatters Hub Statistics July 2023 – September 2023

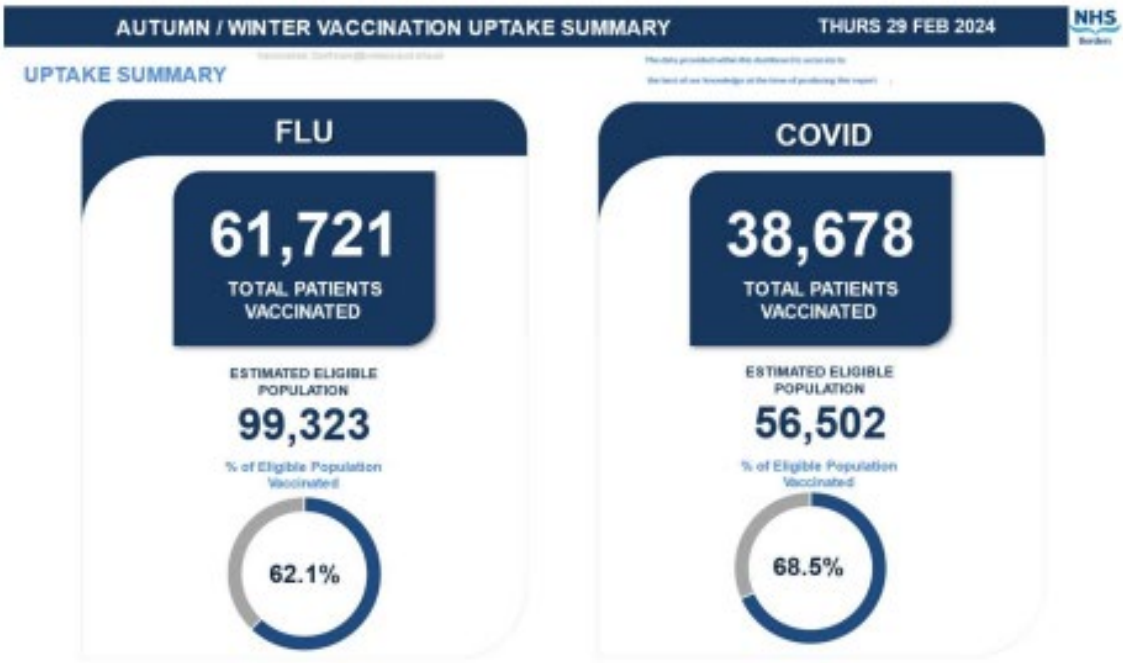


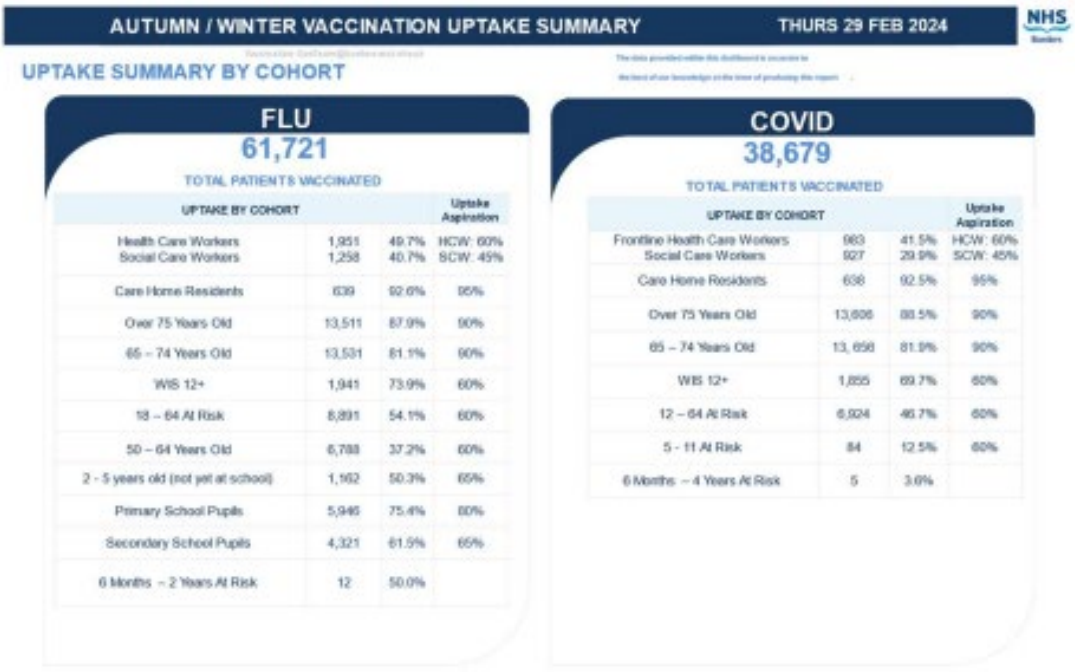






Covid and Influenza Vaccination uptake





AUTUMN / WINTER VACCINATION UPTAKE SUMMARY THURS 29 FEB 2024

NHS Borders

UPTAKE SUMMARY BY COHORT

FLU

61,721

TOTAL PATIENTS VACCINATED

UPTAKE BY COHORT			Uptake Aspiration
Health Care Workers Social Care Workers	1,951 1,258	49.7% 40.7%	HCW: 60% SCW: 45%
Care Home Residents	639	92.6%	95%
Over 75 Years Old	13,511	87.9%	90%
65 – 74 Years Old	13,531	81.1%	90%
WIS 12+	1,941	73.9%	60%
18 – 64 At Risk	8,891	54.1%	60%
50 – 64 Years Old	6,788	37.2%	60%
2 - 5 years old (not yet at school)	1,162	50.3%	65%
Primary School Pupils	5,946	75.4%	80%
Secondary School Pupils	4,321	61.5%	65%
6 Months – 2 Years At Risk	12	50.0%	

COVID

38,679

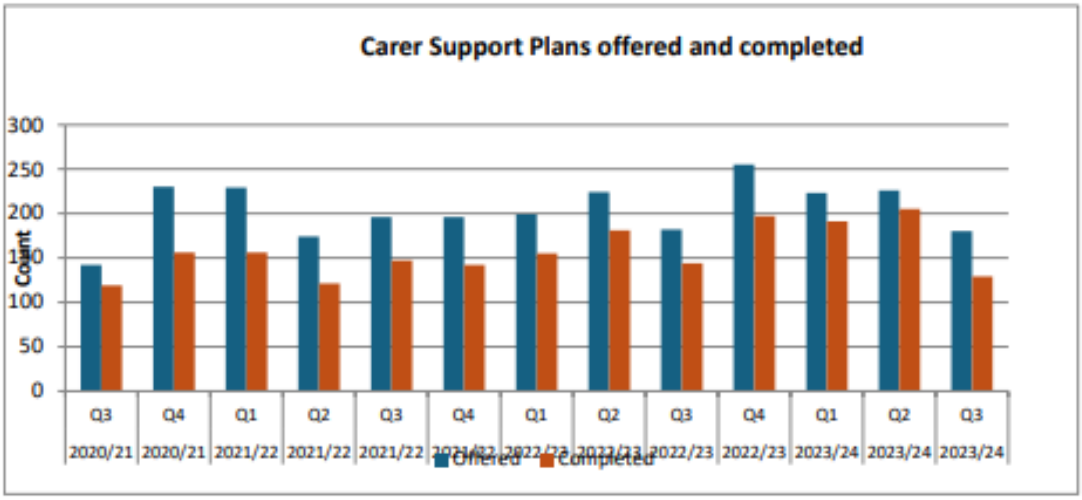
TOTAL PATIENTS VACCINATED

UPTAKE BY COHORT			Uptake Aspiration
Frontline Health Care Workers Social Care Workers	983 927	41.5% 29.9%	HCW: 60% SCW: 45%
Care Home Residents	638	92.5%	95%
Over 75 Years Old	13,606	88.5%	90%
65 – 74 Years Old	13, 658	81.9%	90%
WIS 12+	1,855	69.7%	60%
12 – 64 At Risk	6,924	46.7%	60%
5 - 11 At Risk	84	12.5%	60%
6 Months – 4 Years At Risk	5	3.6%	

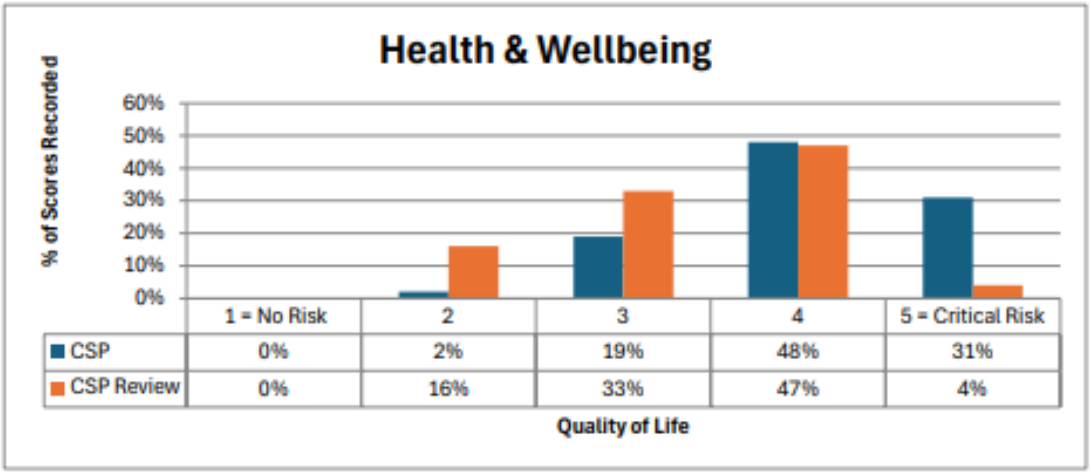
Objective 4: Supporting unpaid carers by getting services for the cared for right

Unpaid Carers offered and completed Carer Support Plans

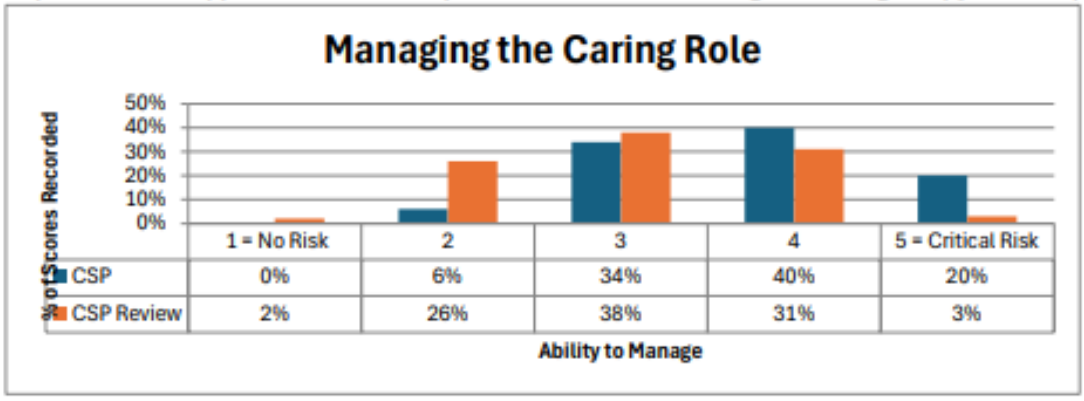
Source: Borders Carers Centre



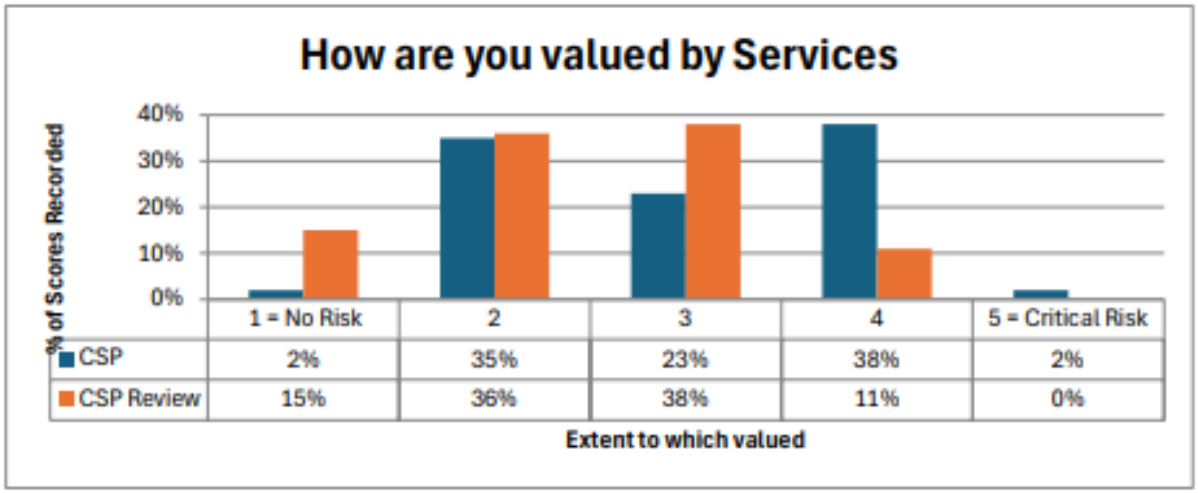
Impact of Carer Support Plans (CSPs) on reported health and wellbeing of Unpaid Carers (Q3 2023/24)



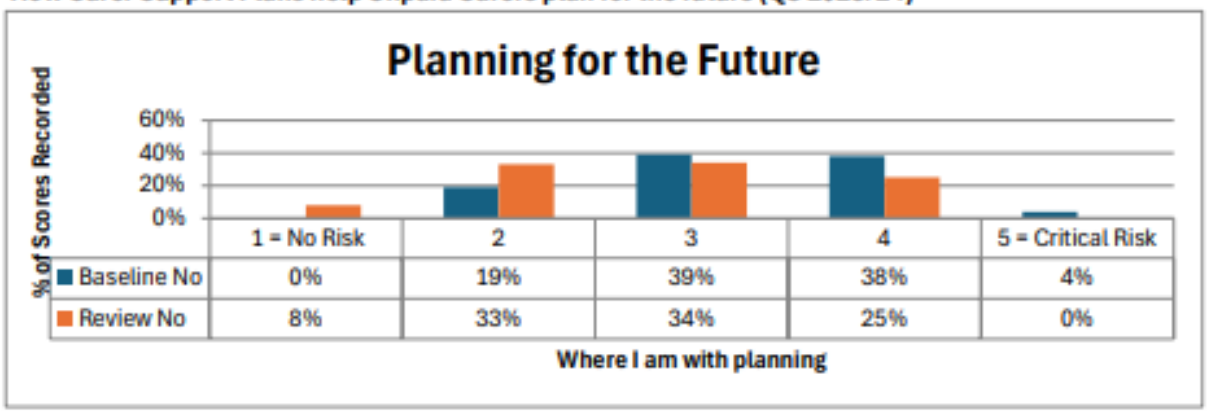
Impact of Carer Support Plans on how Unpaid Carers are able to manage the Caring role (Q3 2023/24)



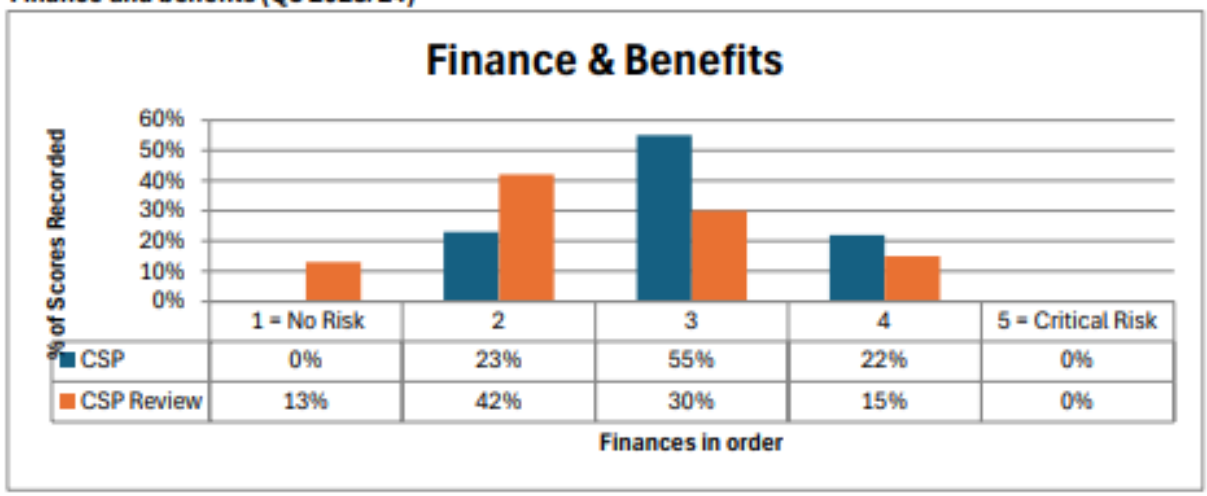
Impact of Carer Support Plans on how Unpaid Carers feel valued by services (Q3 2023/24)



How Carer Support Plans help Unpaid Carers plan for the future (Q3 2023/24)



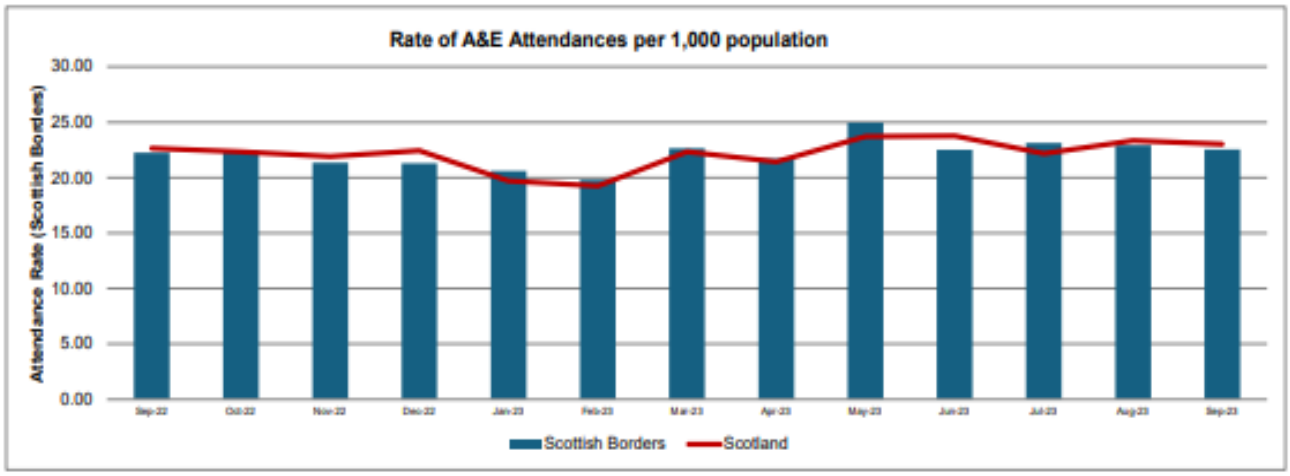
Finance and benefits (Q3 2023/24)



Objective 5. Improving effectiveness and efficiency

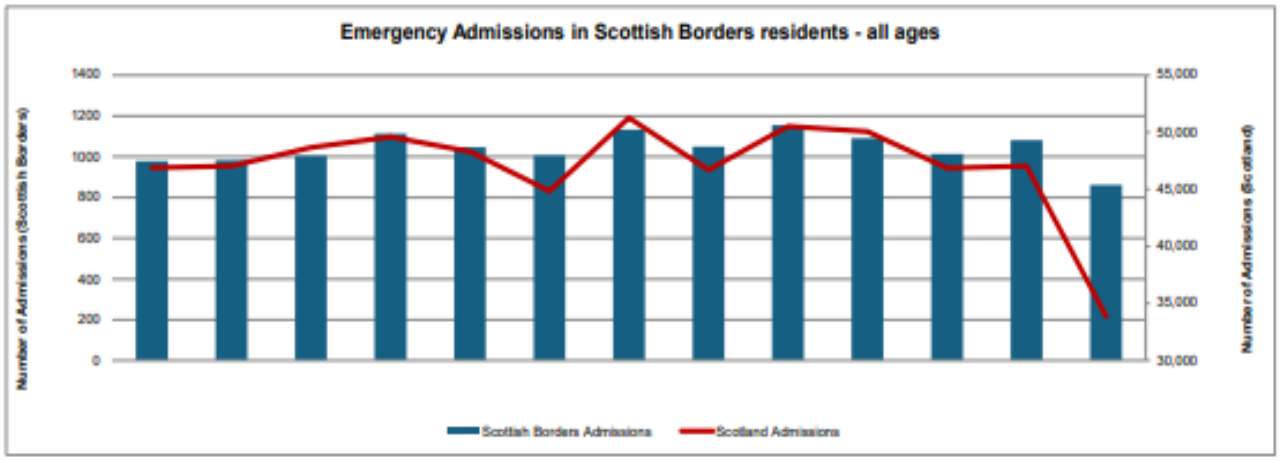
Rate of A&E Attendances per 1,000 population

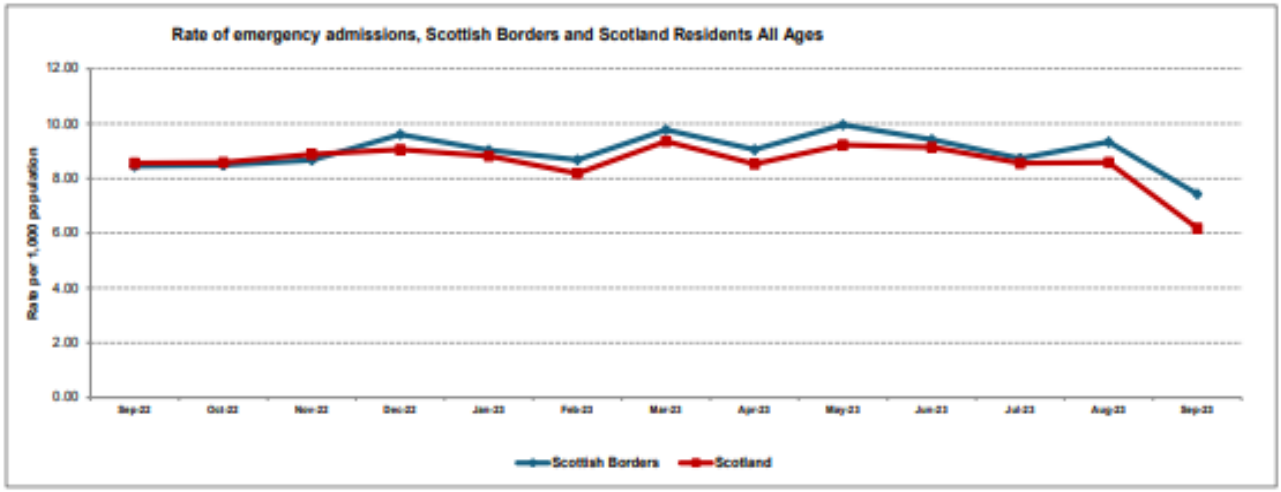
Source: MSG Integration Performance Indicators workbook (data from NHS Borders Trakcare system)



Emergency Admissions, Scottish Borders residents All Ages

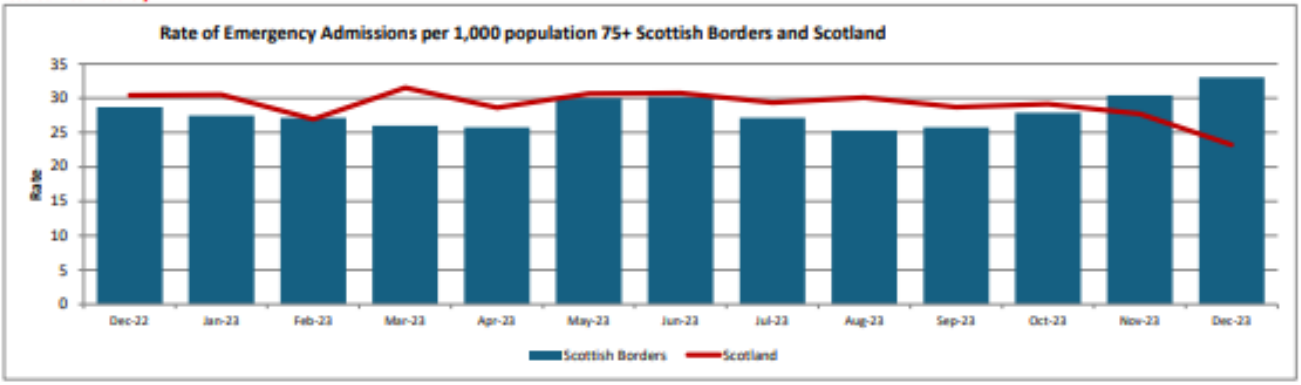
Source: MSG Integration Performance Indicators workbook (SMR01 data)





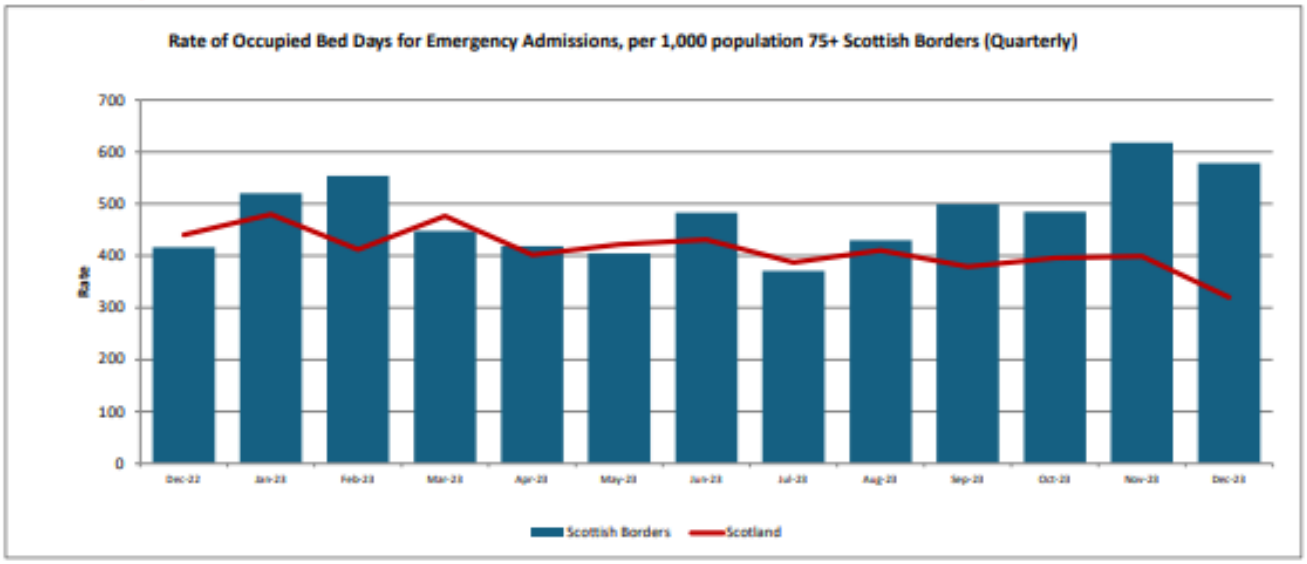
Emergency Admissions comparison, Scottish Borders and Scotland residents age 75+

Source: NSS Discovery



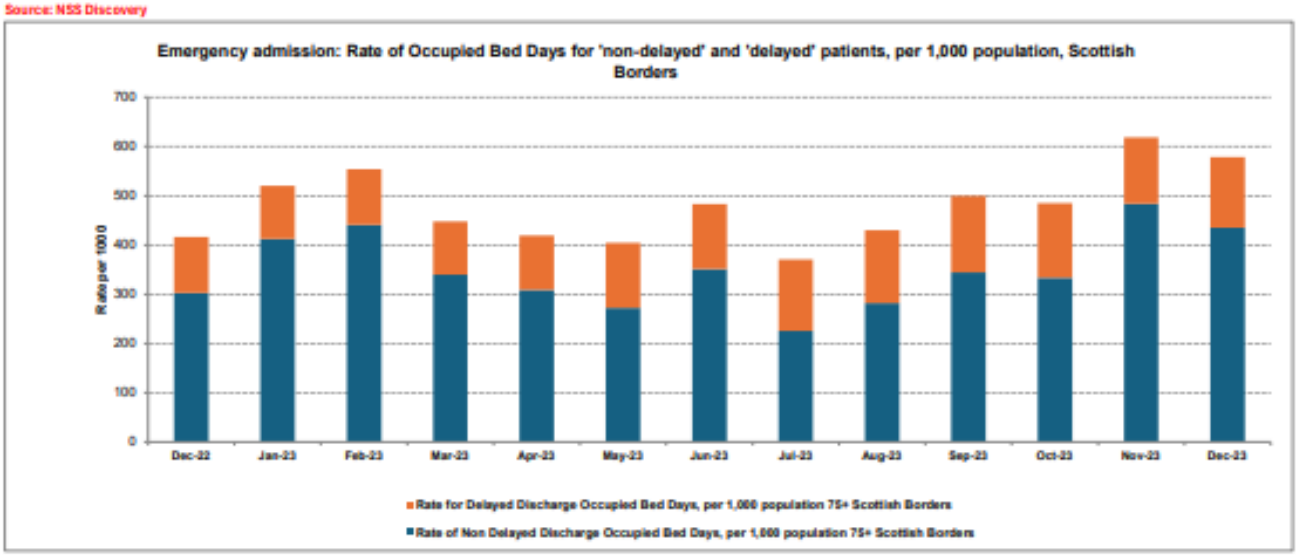
Occupied Bed Days for emergency admissions, Scottish Borders and Scotland Residents age 75+

Source: NSS Discovery



Breakdown of occupied bed days associated to treatment, versus days waiting for care

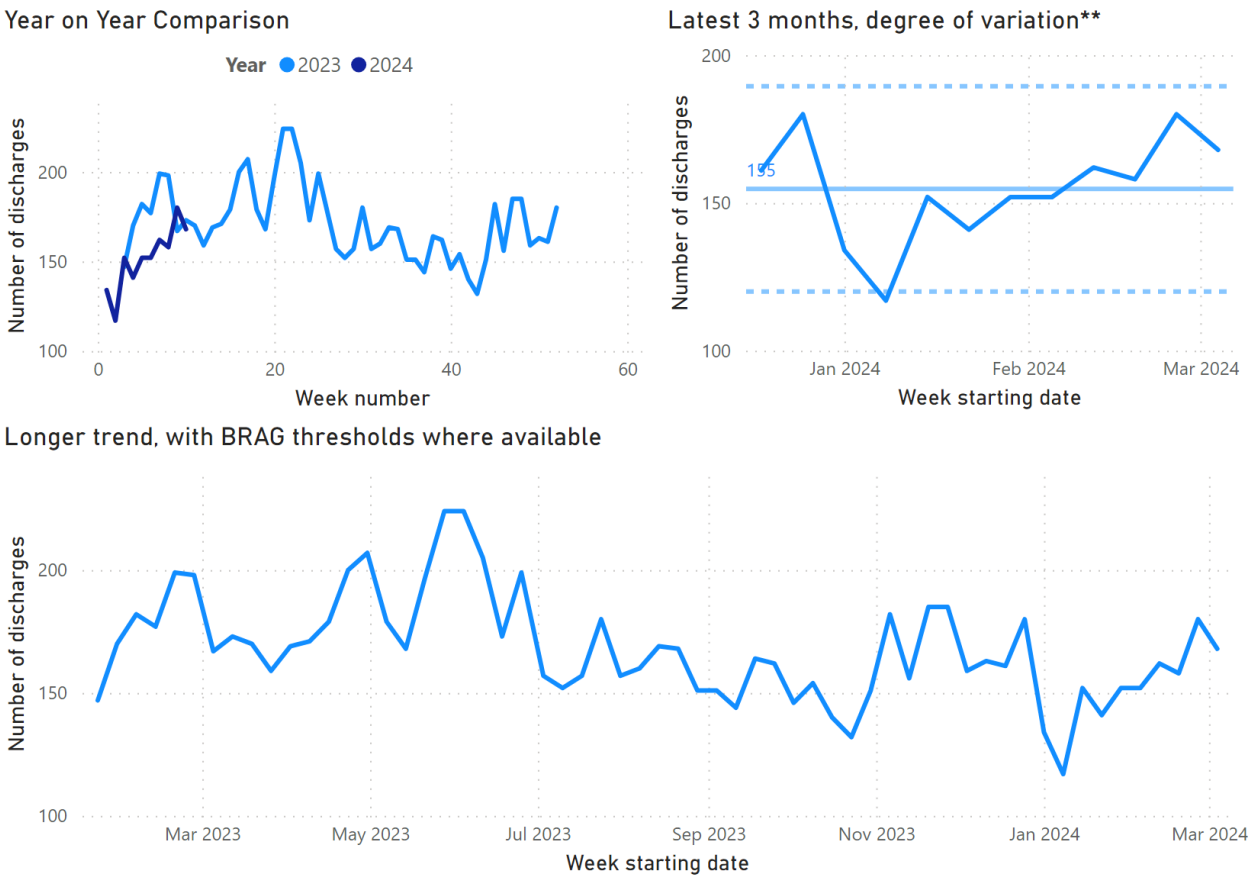
Source: NSS Discovery



Please Note: where two areas are concerned it is not possible to show values as a control chart.

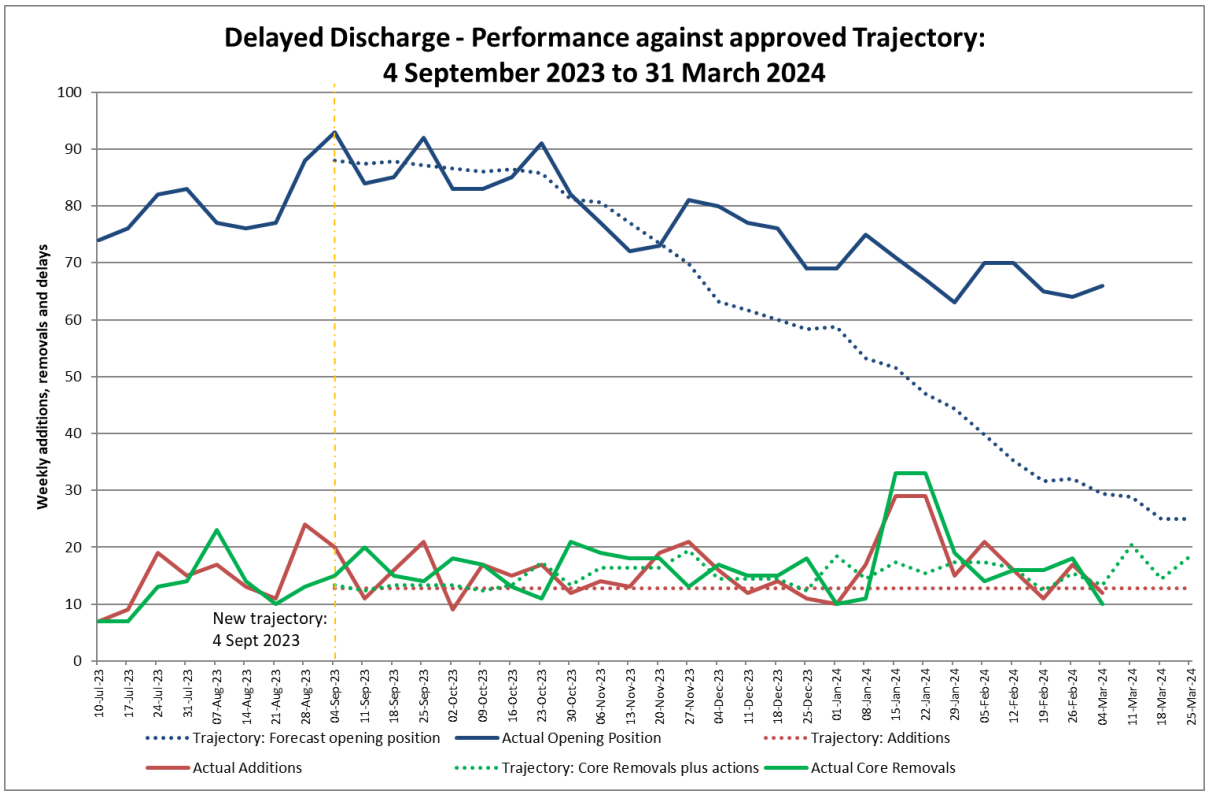
Source: NHS Borders Trakcare system

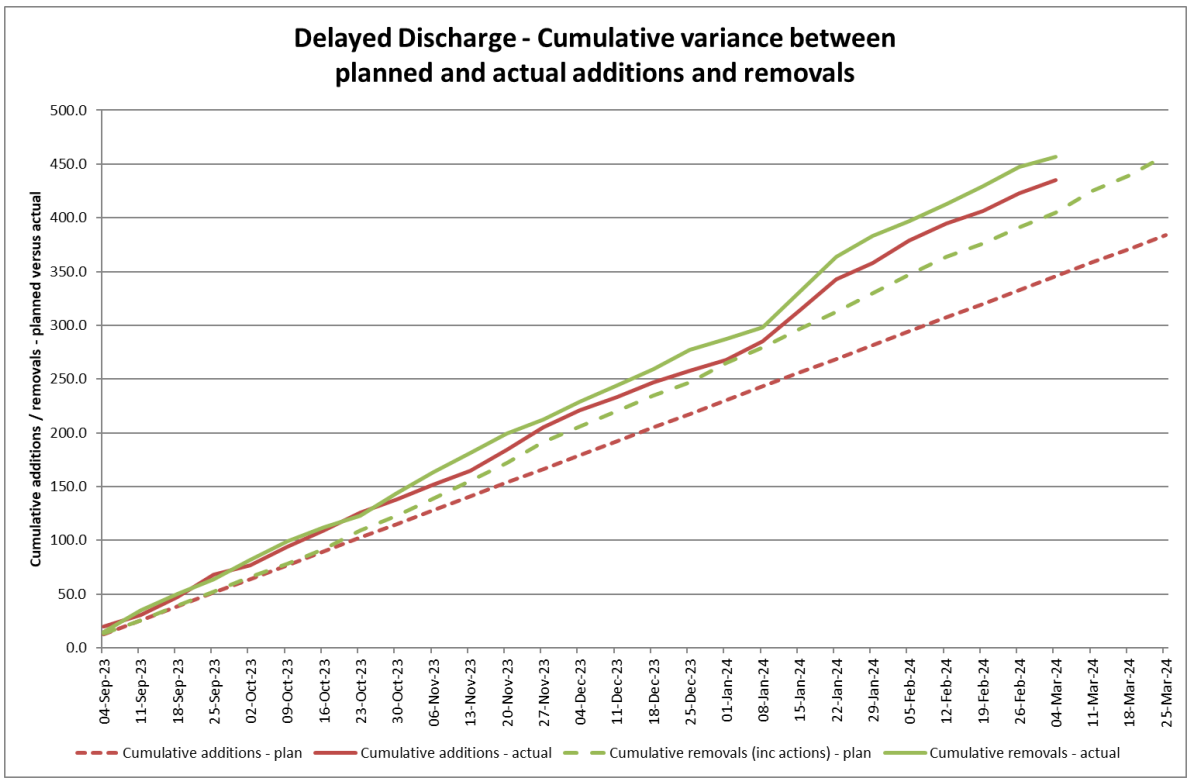
Discharged without Delay



Out of 174 discharges in the latest reported week, there were 168 patients discharged without delay (4th March 2024) – 96.5%.

Delayed Discharge




Delayed Discharge - Cumulative variance between planned and actual additions and removals
Cumulative additions / removals - planned versus actual
500.0
450.0
400.0
350.0
300.0
250.0
200.0
150.0
100.0
50.0
0.0
04-Sep-23
11-Sep-23
18-Sep-23
25-Sep-23
02-Oct-23
09-Oct-23
16-Oct-23
23-Oct-23
30-Oct-23
06-Nov-23
13-Nov-23
20-Nov-23
27-Nov-23
04-Dec-23
11-Dec-23
18-Dec-23
25-Dec-23
01-Jan-24
08-Jan-24
15-Jan-24
22-Jan-24
29-Jan-24
05-Feb-24
12-Feb-24
19-Feb-24
26-Feb-24
04-Mar-24
11-Mar-24
18-Mar-24
25-Mar-24
Cumulative additions - plan
Cumulative additions - actual
Cumulative removals (inc actions) - plan
Cumulative removals - actual

Appendix 2: Directions tracker:

Ref	Date	Service	Purpose	Direction	Value £000s	Outcomes	Mar-23
SBIJB-151221-1	02/02/22	Workforce	Development of plan	Development of a HSCP Integrated Workforce Plan, including support of immediate workforce sustainability issues			Complete
SBIJB-151221-2	02/02/22	Strategic Commissioning	Development of plan	Resource support for the development of the IJB's Strategic Commissioning Plan			Complete
SBIJB-151221-3	02/02/22	Care Village Tweedbank and Care Home Hawick	Development of FBC	Development of Full Business Cases for Care Village in Tweedbank, and the scoping of Care Home Provision in Hawick to Outline Business Case		Revised direction below	
SBIJB-020322-1	02/02/22	Millar House	Commissioning	Commissioning the Millar House Integrated Community Rehabilitation Service	£256k R	Quality of care, Length Of Stay, Costs	
SBIJB-150622-2	16/06/22	Day services for adults with learning disabilities	Commissioning	To re-commission a new model of Learning Disability Day Services by going to the open market	1,643,000	Savings target £350,000. All nine health and well being outcomes	
SBIJB-150622-3	16/06/22	Pharmacy support to social care users	Polypharmacy	To provide an Integrated service for all adult social care service users	NR £150k	Savings will be identified to CFO. Review of service after two cycles	

SBIJB-150622-4	16/06/22	All	Budgetary framework	To deliver services within the budgets and under the framework outlined in Item 5.7 of the 15 June 2022 Integration Joint Board			
SBIJB-151221-3	21/09/22	Care Home Hawick update	Development of FBC	Hawick Outline Business Case		Present business case	
SBIJB-150622-5	16/06/22	Health Board Oral Services	Development of plan	To provide support for the production of an Oral Health Plan	As per SoI	Focussed on planning principles, health improvement plan, and be financially sustainable	
SBIJB-210922-1	21/09/22	Hospital at home	Scope the development of Hospital at home	Develop a business case to come back to IJB for approval	300	To be discussed at range of groups prior to IJB in March	
SBIJB-210922-2	21/09/22	Integrated home based reablement service	Report to IJB with business case for integrated SB Cares and Home First Service	Develop a business case to come back to IJB for approval	expected that costs will reduce	To review by SPG before IJB in December	Further work required based on constraints noted in the introduction

SBIJB-210922-3	21/09/22	Palliative Care review	To commission an independent palliative care review	Scope and outcomes as described in paper with full engagement and integrated approach. To improve outcomes and reduce costs through a programme budgeting approach	-	To conclude by 31 March 2023. Review by SPG before IJB	The IJB agreed to defer this workstream to the 2024/25 Delivery Plan
SBIJB-020922-1	21/09/22	Primary Care Improvement Plan	Manage PCIP within existing funding	PCIP Exec to deliver outcomes from non recurrent spend, and reprioritise the use of available recurrent funding. PCIP Exec to escalate at a national level regarding inadequacy of funds and the risks associated with that.	£1.523 NR and £2.313 rec plus tranche 2 tbc	Implementation of GP contract	Implementation of national PCIP Demonstrator is expected to make this Green for 2024/25
SBIJB-161122-1	16/11/22	Day services	Review of need for day service	Engage in partnership working, through an IIA, consider and evaluate options, including financial impact, outline scope of service, ensure full engagement			
SBIJB-010223-1	01/02/23	Hawick Care Village	Scoping of the associated integrated service models of delivery	Scoping of the associated integrated service models of delivery and associated revenue costs for the Full Business Cases for the Hawick and Tweedbank Care Villages		Business case	

SBIJB-190423-1	19/04/23	Gala Resource Centre	Service closure and transformation for Emotionally Unstable Personality Disorder	Close the Gala Resource Centre and Earmark funds for Emotionally Unstable Personality Service	£166,656 savings to support budgetary pressure	To collect performance information for Emotionally Unstable Personality Disorder Service	
SBIJB-190423-2	19/04/23	Annual Services and budget direction 2023/24	Annual services and budget direction for 2023/24 to NHS Borders and Scottish Borders Council	To work collaboratively within the budgets and parameters outlined, complying with IJB guidance	£201.792M	Strategic framework, National Health and Wellbeing outcomes, delivery of financial targets	Due to current overspend (reviewed at December 2023 IJB Audit Committee)
SBIJB-170523-1	17/05/23	Teviot and Liddesdale Day Services	Commissioning of day service	To implement the business case, and further develop day services across the region	£173K	National Health and Wellbeing outcome for unpaid carers	
SBIJB-170523-2	17/05/23	Locality Working Group	Establishment of the Eildon Community Integration Group	To undertake a pathfinder to determine future model	£150K	Supporting the Strategic Framework, with a focus on prevention and early intervention, and reducing poverty and inequalities	
SBIJB-170523-3	17/05/23	Night support pathfinder in Duns	Pathfinder of night support service in Adult Social Care in Duns	To undertake a pathfinder and associated review of night support service in Duns	Expected potential saving of £450K across Scottish Borders	Improve service user experience, increase National Health and Wellbeing outcomes, improved financial sustainability	

SBIJB-190723-1	19/07/23	Unscheduled Care flow	Surge planning	To commence the surge planning process for Winter, and reduce delayed discharge, closing surge capacity	n/a	Positive impacts across National Health and Wellbeing Outcomes	Delayed discharges are higher than planned and surge capacity has not as yet been closed
SBIJB-190723-2	19/07/23	Primary Care Improvement Plan	Implementation of the PCIP Bundle	To implement the bundle plan outlined in the report, escalate funding concerns to Scottish Government and approve the financial model	£96K year 1, £38K year 2, £355K year 3	Improvements across National Health and Wellbeing Outcomes	Superseded by successful PCIP Demonstrator
SBIJB-200923-1	20/09/23	Hospital at Home	Hospital at Home pathfinder	To undertake a 6 month test of change pathfinder as a transformation programme, so that a case can be presented to the IJB	£319K non-recurrently to the end 23/24	Business case including outcome measures	
SBIJB-151123-1	15/11/23	Community Hospitals	Community Hospital cover	To develop a robust process that works to ensure that an effective sustainable model identified in the short term in the Knoll and Kelso Community Hospitals, and that over the longer term a model fit for the future in line with need is developed	No costs	No adverse impacts on National Health and Wellbeing outcomes	
SBIJB-240124-1	23/01/24	Reprovision of Night Support	Reprovisioning of Adult Social Care Night Support service	To implement the 'Reprovisioning of night support service' report recommendations considered by the Integration Joint Board. This includes review at 6 months in the IJB Audit Committee	Further savings of £158,035 beyond the first phase are anticipated, bringing the total recurring	It is expected that the proposal will improve National Health and Wellbeing outcomes 2, 3, 4, 6, 8 and 9.	

					saving to £343,692 per annum.		

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Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 March 2024

2024/25 IJB Financial Plan and Initial Budget

Report by Lizzie Turner, Chief Financial Officer (Interim)

1. PURPOSE AND SUMMARY

1.1. The paper the sets out the Scottish Borders Council 2024/25 payment offer to the Integration Joint Board for consideration and approval, sets out financial planning assumptions, and sets out a proposed outline budget for local authority delegated services, which will be confirmed when we have received both payment offers, considered the impacts and aligned this to the priorities of the Strategic Framework.

1.2. The figures within this paper are solely based on the funding available by Scottish Borders Council as we have not received a payment offer for NHS Borders. A further update confirming the NHS Borders payment offer will be brought to the IJB once it has been made available to Officers.

1.3. The financial challenges facing the wider public sector are well documented and it is expected that the IJB will face increasing financial pressures during 2024/25 and beyond, the initial value of which will be quantified once the full funding position is known and available.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked:-**

a) To approve the Payment Offer from the Scottish Borders Council;
b) To note that the Payment Offer from NHS Borders is outstanding at this time and is required before the IJB budget can be finalised;
c) To request a full initial budget be brought to the IJB in April for approval upon receipt of the outstanding offer; and,
d) To note the risks described in the paper.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
x	x	x	x	x	x

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x	x	x	x	x	x

4. INTEGRATION JOINT BOARD DIRECTION

4.1. The annual budget direction will be issued once both payment offers have been received, agreed and the final budget has been set. The budget direction will work to set a budget in line with the priorities of the Strategic Framework.

5. BACKGROUND

5.1. There is a requirement for the IJB to set their budget by 31st March each year. To this end the Chief Officer IJB wrote to Scottish Borders Council and NHS Borders on 22 December 2023 on behalf of the IJB detailing the ask of the IJB.

5.2. Scottish Borders Council have made their payment offer, following approval of their budget in Council on 29th February.

5.3. The IJB has not yet received its annual payment offer from NHS Borders as they are still agreeing their draft Financial Plan with the Scottish Government. We are working closely with finance colleagues to understand when the information is likely to become available and this will be brought to the Board as soon as practicable. In the meantime, the IJB is able to review the payment offer from Scottish Borders Council, and work to set a budget in line with the Strategic Framework, and this forms the basis of the paper.

5.4. The HSCP Delivery Plan for 2024/25 is being drafted but cannot be complete before the full funding position is known, and before the Health Board sign off their Annual Delivery Plan. This delay, and potentially the value of the NHS offer, may impact on the IJBs ability to deliver against the Strategic Framework 2023-26. The 2024/25 IJB budgets will be brought to the Board for approval as soon as we receive the payment offer, and the setting of the budget will inform the HSCP Delivery Plan for 2024/25.

5.5. It is our intention to bring a three to five year financial plan to the IJB in the summer, to provide a direction of travel and indicative figures for future years. This is an essential process to continuing to work to improve local outcomes, and ensuring financial sustainability. However this process will rely on the required information being available from our funding partners. A letter will be sent by the IJB Chief Finance Officer (Interim) to the Directors of Finance in NHS Borders and the Scottish Borders Council to seek their support.

5.6. The financial challenges facing NHS Scotland and the wider public sector are well documented and Caroline Lamb, Director General Health and Social Care and Chief Executive of NHS Scotland wrote to Board Chairs and Chief Executives during 2023/24 requesting that NHS Boards take action to reduce their forecast overspends. Similar action has been taken within Scottish Borders Council and in the current economic climate the financial position is not expected to improve in the short to medium term.

5.7. It is therefore expected the IJB will face similar financial pressures during 2024/25 and beyond, the initial value of which will be quantified initially once the full budget is available.

5.8. Regular financial reporting throughout the year will ensure the IJB is kept informed of any changes affecting the assumptions made in the budget and how forecast spend compares to the budgets agreed.

5.9. Audit Scotland published their Financial Analysis of Integration Joint Boards in April 2023 and reported that "IJBs face considerable financial uncertainties and workforce challenges. – Efficiency and transformational savings alone may be insufficient to meet future financial challenges. Significant transformation is needed to ensure financial sustainability and service improvements. – The social care sector cannot wait for a NCS to deal with financial, workforce and service demand challenges– action is needed now if we are to improve the outcomes for people who rely on health and social care services."

5.10. This acts as a reminder of the scale of challenge that the IJB will face over the coming years however with this is an opportunity to drive efficiency and improvement throughout the system.

6. GENERAL PRINCIPLES

6.1. The Scheme of Integration (SOI) for Scottish Borders Integrated Joint Board requires that the IJB agree its budget annually with Scottish Borders Council and NHS Borders in line with joint financial planning arrangements.

6.2. Resources available to the IJB are based on historic agreed budgets amended for items agreed through the financial plans of partner organisations, including a share of local government financial settlement and the uplift to the NHS Board Revenue Resource Limit, as well as any further items directed as a result of national policy or otherwise agreed by partner bodies.

6.3. Savings targets are determined based on any shortfall against the level of resources available to the IJB and its agreed investments.

6.4. The IJB is expected to deliver the outcomes identified within its strategic framework from within the totality of resources available. In some cases additional resources may be made available during the year to meet strategic priorities not included within the original plan. This includes allocation of additional resources by Scottish Government through partner bodies. Where resources are directed at functions delegated to the IJB. Partners are expected to pass on these resources in full.

6.5. The IJB has the ability to hold ring-fenced reserves to retain planned underspends.

6.6. The IJB has a requirement to meet financial balance and this cannot be achieved until the NHS offer is received and approved. The HSCP Delivery plan is being drafted and will be completed upon agreement on the NHS Borders Payment Offer at which point there will be clarity over the 2024/25 funding position and associated savings requirements. Once approved, budgets and plans for delivering savings can be confirmed with Scottish Borders Council and NHS Borders.

6.7. Where there is a forecast overspend across the budgets set for delegated functions "the Chief Officer and the Chief Finance Officer of the Integration Joint Board must agree a recovery plan to balance the overspending budget" (Scottish Borders Scheme of Integration, Section 8.6).

6.8. The Scheme of Integration (SOI) makes provision for partner organisations to provide additional resources to the IJB where its recovery plan has been unsuccessful in a given year. Under the terms of the SOI amounts provided to meet this gap are repayable to the partners in future periods.

6.9. Delivering a balanced financial plan requires a number of assumptions to be made in relation to the level of resource provided, notably in relation to public sector pay policy and inflationary pressures. In both cases the assumptions made are based on partner bodies planning assumptions and consistent with Scottish Government advice, however economic forces at a national and international continue to present challenge to these planning assumptions.

7. ASSUMPTIONS

7.1. The impact of known and expected costs and pressures has been modelled across the partner's services to identify the level of funding the IJB requires for 2024/25 to fully fund commissioned services.

a) Pay pressures have been calculated on the basis of a 3% increase but there is no confirmation yet as to what pay inflation may be agreed nationally.
b) Non pay inflation has been estimated in line with Scottish Borders Council non pay assumptions. The impact of macro-economic factors on general inflation will remain a risk to partner organisations and will be considered further via quarterly reviews.

8. NHS FUNDING POSITION

8.1. In October 2023 Richard McCallum, Director of Health Finance and Governance wrote to all NHS Boards asking that for 2024/25 NHS Boards provide a clear programme of work and supporting actions to achieve the target of 3% recurring savings on baseline budgets; and an improved forecast outturn position compared to your forecast outturn position reported at the start of 2023-24.

8.2. Since then, NHS Borders has undertaken this programme of work and submitted its first draft Financial Plan to Scottish Government w/c 11th March 2024. This programme of work has focused on identifying options for delivering a minimum of 3% recurring savings in 2024/25 as part of a wider medium-term target of 10% over the three financial years 2024/25 to 2026/27. As a result of the plans in place, the overall Financial Plan gap has reduced considerably but at the current time of writing is still in excess of brokerage requirement expected by the Scottish Government. Work will continue developing and refining the plan over the next month or two and discussions remain ongoing with the Scottish Government over the level of support that will be available next financial year. The draft Financial Plan will form the basis of the opening Provision of 2024/25 Resources to the IJB and this will be further developed following discussions between NHS Borders and the IJB.

8.3. A 15 Box Grid has been approved by Board Chief Executives which sets out 15 areas of focus for Boards to progress. The Financial Delivery Unit is available to support this work. These 15 themes form part of the medium-term savings programme that is

being developed by NHS Borders covering a range of strategic themes such as Medicines and Prescribing, Workforce and Productivity. One of the key challenges underpinning the affordability of the Financial Plan is that whilst strenuous efforts are being made to put plans in place to deliver savings, costs continue to increase at unprecedented levels due to a combination of increased activity, further demand and directed outcomes and escalating inflationary pressures. Such increased costs are simply not matched by increases in central government funding levels. The costs of medicines prescribed for example has increased by 15% during 2023/24, only part of which has been able to have been mitigated by savings implemented.

8.4. The letter of 19th December confirmed that the confirmed that Health consequentials from the UK Government had been lower than anticipated putting further financial pressure on NHS Scotland. Territorial boards received an 4.3% increase on 2023/24 funding, including recurring funding for the 2023/24 pay award, the 2023/24 NRAC funding being allocated recurrently and the £100m Financial Sustainability funding provided in 2023/24 being baselined. As a result, no boards are now no further than 0.6% from NRAC parity. Scottish Government has indicated that the 2024/25 pay award will also be fully funded but otherwise pressures should be managed within Boards.

8.5. It was noted that although COVID 19 costs have reduced significantly in 2023/24 some additional allocations will be made in 24/25 to cover Vaccinations, Test & Protect activities including Regional Testing facilities, Additional PPE requirements and some specific Public Health measures. Some delegated and set-aside functions continue to bear now-unfunded or only partially-funded financial cost pressures as a legacy of Covid 19 in areas such as Care Home Nursing Leadership, Infection Control, Vaccination and the Emergency Department.

8.6. Scottish Government have also confirmed that Capital funding will reduce in 2024/25 with no new projects being commissioned for at least 2 years.

8.7. Although an indicative payment offer is not yet available from NHS Borders, based on the information available we understand that the situation is likely to be very challenging.

9. SBC PAYMENT OFFER AND FINANCIAL CONTEXT

9.1. Scottish Borders Council received confirmation of its funding from Scottish Government in December 2023 and set its 2024/25 budget on 29 February 2024.

9.2. Scottish Borders Council approve a 5 year Financial Plan each year which confirms Year 1 budgets and provides provisional funding and budgets for Years 2-5 based on a range of assumptions around funding and costs.

9.3. Over the 5 years of the plan to 2028/29 £18.1m of recurring savings are required and Scottish Borders Council is working to create a new long term plan to deliver Transformational change over the next 10 years. Whilst efficiency will remain a key focus of the Council it is anticipated that permanent budget reductions will be made to services as well.

9.4. Due to the financial challenges facing Scottish Borders Council c£10m of Reserves are being used in 2024/25 to balance the financial position in addition to a £4.4m savings target.

9.5. Although a full funding package of £13.6 billion was available to Local Authorities nationally, this presented a real-terms cut in both revenue and capital funding to the Council with the freeze on Council Tax reducing the ability of the Council to generate additional income.

9.6. Within the £13.6 billion Scottish Government confirmed a number of additional funding allocations for social care, including £230m in order to deliver a minimum £12 hourly rate for all adult care workers in commissioned services, £11.5m to provide an inflationary uplift to Personal and Nursing Care rates and £0.176m for Self-Directed Support. No additional funding was provided to support increased demographics.

9.7. The Scottish Borders IJB share of the funding described in 7.6 includes:

- Self-directed Support £0.005m
- Personal & Nursing Care for Elderly £0.434m
- Real Living Wage £5.272m

9.8. Whilst the Scottish Government have provided clarity on the funding package that they expect to be delegated to the IJB for 2024/25, it has not yet been confirmed what expenditure is assumed to be covered by this funding. This means further work is required, once this clarification is received from Scottish Government, to confirm detailed budget allocations.

9.9. The payment offer from SBC is £81.551m, a £7.9m increase on last year. This includes £1.9m of additional funding support increased workforce costs following the 2023/24 pay agreement and the additional funding provided by Scottish Government. It should be noted that whilst the increased funding is welcome, the funding is very much directed to supporting inflationary increases such as salary increases including Real Living Wage and payments to external partners to increase pay to a minimum of £12 per hour. It is therefore not available for increased demand pressures within the system.

9.10. As part of the Payment request made to both Scottish Borders Council and NHS Borders in December 2023 the IJB requested a number of terms including:

- Pay and non pay uplifts to be included within the offer,
- An assumption for demographic growth
- National funding allocations to be delegated to IJB at the point of receipt,
- All delegated budget areas to be included, and
- Support for the highest risk areas be provided.

9.11. It is considered that these terms have largely been met within the payment offer made by the Scottish Borders Council, but it should be noted that work to estimate future demographic growth requirements and the intended use of Scottish Government funding is ongoing. Should unfunded demand pressures arise during the year they will be raised through normal financial monitoring processes.

10. OUTLINE IJB BUDGET (LOCAL AUTHORITY DELEGATED SERVICES)

10.1. The table below aligns the SBC £81.551m to service areas based on the strategic priorities of the IJB, and information to date. The table also includes details about outstanding brought forward savings.

Table 1 : Initial IJB budget by Service £000s

Service	2023/24 Budget	Inflationary increases	Workforce increases	New SG funding*	2024/25 Savings required	2024/25 Budget	Savings B/F
Generic Services	8,430	2	326	5	0	8,763	(98)
Joint Learning Disability	21,081	1	88	0	(200)	20,970	(246)
Joint Mental Health	2,267	0	71	0	0	2,338	
Older People	23,431	0	76	6,156	(4)	29,659	(275)
People with Physical Disabilities	2,801	0	0	0	0	2,801	
Adult Social Care	15,661	4	1,356	0	0	17,021	(505)
Total	**73,670**	**7**	**1,917**	**6,161**	**(204)**	**81,551**	**(1,124)**

***funding will be allocated across services reflecting the anticipated increase per service provider once confirmed

10.2. Within the funding received from Scottish Borders Council there is a requirement to deliver £1.328m savings during 2024/25. £1.124m of this are brought forward savings not yet delivered recurrently with a requirement of £0.204m in new savings to be delivered in 2024/25.

Table 2: Detail of delegated local authority service saving requirements

Description	£000s
Shared Lives	200
Additional fees & charges income	4
Bordercare Alarms	75
Reablement of Homecare	285
Better use of Fleet Vehicles	45
Residential Care Re-tendering	100
Reablement savings via commissioning	619
Total	**1,328**

10.3. It should be noted that during Financial Year 2023/24 significant pressures in Adult Social Care were experienced and funded from elsewhere within the IJB and the pressures in this area are anticipated to remain over the coming years in line with increased demand and therefore need to be managed alongside delivering savings.

10.4. Prior to agreement of the IJB's 2024/25 Financial Plan, once the payment offer from NHS Borders has been received, and the budget is being set for health delegated functions, the IJB will have to be cognisant of the Health Board's proposed savings plans which are in development. It is unlikely that any undelivered savings in prior financial years will be brought forward and the new plans will reflect only the measures identified to deliver 3% minimum recurring and 1% minimum non-recurring savings in 2024/25 as part of the wider 10% medium-term target.

10.5. To ensure the IJB has time to implement and benefit from savings delivery in 2024/25 it is important that creating full delivery plans is prioritised as we begin the new financial year.

10.6. In addition to identifying savings plans there will be a need to use the Best Value for Every Pound approach to ensure that we invest in services that have greatest impact relative to the amount invested.

11. IMPACTS

Community Health and Wellbeing Outcomes

11.1. The intention of this report is to provide a focus for improvement of health services therefore should indirectly impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Increase
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increase
5	Health and social care services contribute to reducing health inequalities.	Increase
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	Increase
7	People who use health and social care services are safe from harm.	Increase
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

Financial impacts

11.2. The SBC payment offer is £81.551m. Further detail on financial impacts are noted throughout the paper.

Equality, Human Rights and Fairer Scotland Duty

11.3. As part of the 2024/25 Financial Planning process initial impact analyses on proposals brought forward to members for local authority services have been undertaken by the relevant Lead Officer in order to inform the planning and decision making of Senior Officers, the Council Management Team and Council and IJB Members where these services are delegated. This seeks to ensure that any potential impacts form part of the evaluation criteria when considering budget proposals alongside financial benefit, potential impact on performance and outcomes, deliverability and the views of stakeholders. For the Financial Planning proposals a relevant officer undertook an initial evaluation of equality impact and impact on socio- economic groups.

11.4. Those proposals which have been assessed may potentially impact on one or more of the Equality Characteristic Groups or Socio – Economic Groups in a positive or negative way. Any potential negative impact would require ongoing management through each proposal's implementation stage, in terms of mitigating and alleviating these impacts. Any positive impact identified should be maximised during the planning and implementation stage of the proposals. While some of the assessed proposals indicate no impact, it is recommended that any potential impact continues to be monitored, given the nature of the proposals.

11.5. A stage 1 assessment for the budget has been completed and was considered in the last IJB, and this is accompanied by the stage 1 assessment for local authority delegated services. Both impact assessments are enclosed in the background papers section.

11.6. The proposals will continue to be assessed and managed through evidence gathering and mitigation and alleviation in accordance with the IIA process. There will be particular focus on those proposals for in which a potential negative impact has been identified.

Legislative considerations

11.7. Public Bodies (Joint Working) (Scotland) Act 2014 and associated Health and Social Care Integration Finance Guidance.

11.8. The legislation requires that the Integration Joint Board is subject to the audit and accounts regulations and legislation of a body under Section 106 of the Local Government (Scotland) Act 1973.

Climate Change and Sustainability

11.9. Climate change and sustainability considerations will be considered as part of each proposal coming to the IJB.

Risk and Mitigations

11.10. Until the IJB receives its Payment Offer from NHS Borders the ability to deliver the services and improvements in line with the Strategic Framework is not confirmed, and this leads to a delay in setting the budgets and plans for both statutory partners.

11.11. There is a high degree of uncertainty within the current operating environment across Health and Social Care delegated functions, with significant volatility in relation to financial planning assumptions.

11.12. The impact of global events on macro-economic factors has introduced rapid inflationary pressures on fuel, utilities and general costs of living. Variation from planning assumptions will be closely monitored during the year.

11.13. As noted in other IJB papers, we have seen a rising level of need and demand for a range of services. This has a financial and workforce impact, and increases the need for transformation and investment into priority areas.

11.14. In terms of mitigation, effective forward financial planning in line with the Strategic Framework is key. This requires the support of the statutory partners in NHS Borders and Scottish Borders Council, along with wider partners.

12. CONSULTATION

Communities consulted

12.1. The finance teams in NHS Borders and the Scottish Borders Council have been consulted and inputted into this document.

12.2. Further consultation will commence as noted in the impact assessment above.

Integration Joint Board Officers consulted

12.3. The IJB Chief Officer was consulted, and all comments received have been incorporated into the final report.

Author: Lizzie Turner, Chief Financial Officer

Background Papers:

- Payment request letter to NHS Borders and the Scottish Borders Council. Available from: https://scottishborders.moderngov.co.uk/documents/s80435/Appendix-2024-5%20Attach%201%20Request%20for%20payment.pdf
- Integration Joint Board Financial Planning process. Available from: https://scottishborders.moderngov.co.uk/documents/s80437/Appendix-2024-5%20Financial%20Planning%20Process.pdf
- IJB budget stage 1 Integrated Impact Assessment. Available from: https://scottishborders.moderngov.co.uk/documents/s80436/Appendix-2024-5%20Financial%20planning%20process%20stage-1-proportionality-and-relevance.pdf
- Scottish Borders Council budget stage 1 Integrated Impact Assessment. Available from: https://scottishborders.moderngov.co.uk/documents/s81142/Item%20No.%2011%20-%20Appendix%202%20-%20IIAs%20for%20Financial%20Plan%20Proposals%202024-25%20-%20Council%20-%2029%20February%202024.pdf
- Health and Social Care Integration Finance Guidance. Available from: https://www.gov.scot/publications/finance-guidance-health-social-care-integration/

Previous Minute Reference: Not applicable

For more information on this report, contact us at: Lizzie Turner, Chief Finance Officer at lizzie.turner@scotborders.gov.uk

Scottish Borders Health and Social Care Partnership Integration Joint Board

20 March 2024

Virtual Hospital at Home- Funding Proposal

Report by Laura Jones, Director of Quality & Improvement, NHS Borders

1. PURPOSE AND SUMMARY

1.1. **To seek support to progress to a second stage of development for Virtual Hospital at Home Capacity across the Scottish Borders, building on evidence obtained from the recent establishments of Hospital at Home and Respiratory Virtual Ward services**.

1.2. There is a National interest in expanding virtual capacity across Health and Social Care Partnerships to help support system wide flow and complement hospital inpatient capacity. There has been a prolonged and sustained period of pressure across NHS Borders due to several reasons which include high bed occupancy, increased delayed discharges and increased length of stay.

1.3. This has resulted in congestion and overcrowding in the Emergency Department, lengthy waits for inpatient beds and the requirement for unfunded surge beds. Boarding patients out with speciality has impacted on the elective programme. The current situation increases risk of patient harm and has adverse consequences on patient and staff experience.

1.4. The security of funding would see NHS Borders being able to strengthen a new Virtual Hospital service; creating a resilient and sustainable service that offers a safe pathway as an alternative to hospital admission, or to provide early supported discharge for patients who require ongoing clinical supervision.

1.5. The ask to extend funding would support essential workforce development and further virtual beds to be opened (over and above the initial outlay of hospital at home and respiratory virtual ward beds). The additional funding will support the necessary resources, staffing, training and equipment required to accommodate the anticipated increased demand as the service scales up for a broader period of testing.

1.6. This paper provides the Health and Social Care Partnership with the opportunity to deliver an enhanced model of integrated care at an overall reduced cost. The Virtual Hospital project aims to:

- Improve the quality of patient care and wellbeing.
- Reduce the reliance on inpatient care and treatment.
- Reduce the overall costs of care to Health and Social Care
- Reduce occupied bed days and readmission rates into an acute setting.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to approve the allocation of non-recurrent transformation funding to support a year of testing at scale of a combined virtual hospital at home service.**

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
X	X	X	X	X	X

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
X	X	X	X	X	X

4. INTEGRATION JOINT BOARD DIRECTION

4.1. The IJB issued a direction, SBIJB-200923-1, to establish a hospital at home pathfinder for the Scottish Borders. This model was to be developed and tested for the population of Eildon to assess impact and scalability.

4.2. The direction requested a six-month test of change for the Hospital at Home service as a transformation programme, to enable the development of a full Business Case. As part of this test of change, the Health and Social Care Integration Joint Board were supportive of a bid being made to the Scottish Government / Healthcare Improvement Scotland for further funding to support testing.

5. BACKGROUND

5.1. In recent years, healthcare professionals have been considering new ways to respond to the acute care needs of older adults with frailty and other long-term chronic conditions. Where inpatient care is needed, traditional hospital-based models bring a level of risk to older adults. Safe, modern, person centred, community-based alternatives are increasingly being explored at both National and local level. This has resulted in a shift in focus within the NHS towards providing hospital-level care in a person's home environment.

5.2. The Scottish Borders is a rural area which in 2019, had a population of 115,510. The rurality of the region contributes to the fact that 32% of data zones in the Scottish Borders are within the bottom quarter of data zones for access deprivation in Scotland. With 50% of its population living in rural areas, this makes it the most rural mainland coterminous HSCP/Health Board in Scotland[1]. Whilst the size of the Scottish Borders population puts it in the medium sized category it has a large land area and a sparse population density which presents its own challenges in providing health and social care.

5.3. The Borders also has the second oldest population in Scotland with 24.8% of its population over 65 years of age[2]. This is significantly above the national average of 19.10% (the National over 65 population will grow to around our current level in 2045). These demographic characteristics are a major driver of the high demand for health and social care services and the importance of having both local and equitable access to services.

5.4. The Hospital at Home pilot launched in April 2023. It has an inclusive patient criterion encompassing all adults over the age of 18, primarily residing in the central area of the Scottish Borders. The programme is versatile and skilled in overseeing various conditions, including (but not limited) OPAT, Heart Failure, Frailty and General Older People related illness. In its development, the service has also managed to provide some respiratory care (separate to Virtual Respiratory Ward) via ad-hoc support which has been given by the Respiratory Specialist Nurses when required. The Hospital at Home Test of Change gained National recognition form Healthcare Improvement Scotland, for its exemplary collaboration, methodology, governance, data collection and rapid implementation.

5.5. Since the pilot has begun in the Eildon locality, the service has made significant progress in providing acute health care to patients in the comfort of their own home. As of February, a total of 256 patients have been admitted to the programme. On average, patients have stayed for 7.5 days in a hospital at home model. A Borders-wide expansion will provide an opportunity to extend the service to the remaining three localities. There has been a positive impact of caring for patients in their own home retaining their existing care support and preventing deconditioning resulting from being out with a patient's normal environment.

5.6. Following a successful bid for non-recurrent monies from Scottish Government, the respiratory service team developed the infrastructure and pathways for a respiratory virtual ward (RVW) by using remote monitoring equipment supplied through a third-party company – Current Health. NHS Borders are the first Board in Scotland to utilise this equipment in this way. Following rapid planning and development, the virtual ward became operational on Tuesday 23rd January 2024 and has made significant steps in establishing a virtual bed base.

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[1] https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2018/02/understanding-scottish-rural-economy/documents/00531667-pdf/00531667-pdf/govscot:document/00531667.pdf

[2] https://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/scottish-borders-council-profile.html

5.7. During the RVW Test of Change during August 2023 there was 12 virtual ward admissions during a six-week period, with two patients re-admitted to the virtual ward on more than one occasion. The median length of stay was 7.5 days. An estimated 62 occupied bed days were saved during the six weeks the virtual ward was operational.

5.8. In the three months since admissions to the virtual ward were paused a further 41 patients who were admitted to hospital would have been eligible for remote monitoring, with the potential to save 69 additional bed days from early supported discharge.

5.9. The RVW reopened in January 2024 with additional national funding and has seen 36 admissions with an average length of stay of 6.3 days. This has been estimated at an additional 149 bed days saved.

5.10. National funding is due to finish at the end of March 2024 for RVW workstream and at end of June 2024 for Hospital at Home. In the current financial climate, these models will only be affordable if they are able to demonstrate collective value, integration into a single entity (which shared resources and pathways) and cost effectiveness. NHS Borders is currently seeking non-recurring funding to support a year of testing of a combined virtual hospital at home service at full scale across the Scottish Borders.

6. VISION

6.1. For the Health and Social Care Partnership to truly transform, fundamental changes in how we deliver care services to our communities has to change. Our vision is to seamlessly integrate community-based clinical care, creating a connected and convenient system that brings care directly to people's homes. We aim to break down the barriers between traditional health care settings and the local community by connecting patients and their families to high-quality care. Delivering an integrated model that aligns to existing community nursing localities, will enable a joint service to demonstrate these core values described in 1.4 above.

6.2. During this next year, the teams will work together to synergise pathways and create a workforce, with the right skill mix, that will be able to support a larger number of acutely unwell patients at home. This will aim to gain close alignment to locality nursing teams to ensure an effective and resilient workforce model making best use of advanced nursing skill sets across localities.

6.3. There is recognition that any investment during the current financial climate can be considered a risk. However, in order to demonstrate the capability of a truly integrated system (with the potential to offset hospital-based care with community-based care), transformative funding is required; this will support interfacing with other transformational bundles to truly demonstrate system wide change. This is felt to be a critical priority to build a model of care for the long-term future of the Scottish Borders population and ageing demographic outlined earlier in the paper.

6.4. Phase two has been modelled on the service operating 7 days per week between the hours of 8am – 6pm aiming for virtual bed capacity of 48 across the Scottish Borders with the following indicative workforce:

6.5.

- 6.44 WTE X Band 7
- 12.87 WTE x Band 6
- 4.29 WTE x Band 3 HCSW
- 1 WTE x Consultant
- 2 WTE x Middle Grade Doctors

- 1 x WTE Band 4 Admin
- 0.48 WTE x Band 5 Pharmacy Technician

6.6. Phase two aims to take the Virtual Hospital at Home service to scale to demonstrate the resulting impact on occupied beds days to enable a reduction in inpatient beds. Critical dependencies to enable the transfer of inpatient beds to virtual on a recurring basis include the full deliver of other workstreams within the Urgent and Unscheduled Care Programme as well as the full realisation of additional care capacity funded through the IJB. Critical workstreams include:

- Front door flow navigation.
- Older persons care including community hospitals, integrated reablement.
- Surge beds – additional social care capacity.

6.7. In addition, any reductions in existing levels of provision across health and social care need to be closely monitored to understand the impact on whole system bed capacity.

6.8. Phase two will require close tracking of all outcomes and will involve refinement of a proposal around a long-term workforce model, building in any considerations around resources that may be required in the out of hours period. The long-term viability of this model will be dependant to realising the expected benefits to enable the closure of inpatient beds.

7. IMPACTS

Community Health and Wellbeing Outcomes

7.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Increase
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increase
5	Health and social care services contribute to reducing health inequalities.	Increase
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	Increase
7	People who use health and social care services are safe from harm.	Increase
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

Financial impacts

7.2. To develop the model in phase two taking the service full scale will require pump priming transformation funds totalling £2.1 million. The ambition had been to offset some of this cost through national allocations to be ringfenced for this area. However, the national financial challenges facing NHS Scotland now mean that any external allocations are unlikely to be provided. Therefore, it is proposed that a transformation fund is allocated to the IJB for 2024/25 ring fenced to support this area:

Grade	Hours	Hours	Staff	Days	Hours	Uplift	Total Hours	WTE		Total Cost
Nurse band 7	0800-18-00	9.5	3	7	199.5	41.895	241.395	6.44	75,033	483,002
Nurse band 6	0800-18-00	9.5	6	7	399	83.79	482.79	12.87	62,689	807,083
HCSW band 3	0800-18-00	9.5	2	7	133	27.93	160.93	4.29	41,842	179,564
Consultant	40hrs per week only for 52 weeks per year	40	1		40		40	1.2	201,649	201,649
Admin Support band 4	0900-1700 (no holiday cover)	7.5	1	5	37.5		37.5	1.00	37,818	37,818
Middle Grade Doctors	40hrs per week only for 42 weeks per year	40	2		80		80	2.00	107,235	214,470
Pharmacy Technician band 5	15 hours per week for 52 weeks	15	1		15	3.15	18.15	0.48	51,146	24,755
Travel, Supplies and Licenses										150,000
										£2,098,342

Equality, Human Rights and Fairer Scotland Duty

7.3. Each service completed an individual Equality, Human Rights and Fairer Scotland Duty Impact Assessment but a new one will need to be carried out to capture an integrated model.

7.4. Stage 1 – Proportionality and Relevance has been completed at this stage.

7.5. Given the complexities and time pressures at pulling this integrated model together we will look to start Stage 2 and Stage 3 as soon as feasibly possible. This will be done once an integrated model has been scoped out.

Legislative considerations

7.6. Currently there are no relevant legislative considerations that impact the work on Hospital at Home.

Climate Change and Sustainability

7.7. Virtual models can contribute to supporting climate change mitigation and adaption by reducing the carbon footprint associated with traditional hospital care. The service could require less energy-intensive infrastructure compared to traditional hospitals. This includes lower energy requirements for heating, lighting, and other operational needs, resulting in reduced carbon emissions associated with energy consumption. More work would be required to understand the true impact in this area.

7.8. This model aims to provide care in a patient's own residence, reducing the need for resource-intensive hospital equipment/utilities. This includes the efficient use of electricity, medical supplies, and other resources such as laundry facilities.

7.9. The model can also help minimise indoor air pollution by providing care in a patient's home, where air quality can be more easily controlled and maintained compared to traditional hospital where expensively run ventilation and filtration systems.

7.10. Respiratory Virtual Ward estimated it was able to save 1719KgCO2 emissions during a six-week period.

Risk and Mitigations

7.11. Below is a table of the key strategic risks facing the service as it currently stands with potential safeguards and actions in place to mitigate these.

7.12. Two principal categories of risk have been considered: strategic and service.

Ref	Type	Risk description	Possible mitigation
1	Strategic	No national funding is received to deliver the project recurrently.	It is not possible to mitigate for this risk as there are no alternative local sources of funding.
2	Strategic	NHS Borders is currently one of a number of Boards on Scottish Government financial escalation. Therefore, any decision to invest in services must be a risk backed decision and must provide best value not only for the service but for NHSB.	Build evaluation and benefits measurement to ensure business needs are supported and the right rationale for investment.
3	Strategic	Failure to secure sponsorship and support from executive or finance stakeholders	Ensure alignment with local strategic priorities; effective governance to manage stakeholders.
3	Service	Unable to identify supplier who can meet technical service requirements	Horizon scanning of existing remote monitoring solutions; engagement with stakeholders in Scotland and England who have implemented technology enabled virtual wards to share experiences and lessons learned.

4	Service	There are insufficient clinical and administrative resources to deliver a safe and resilient virtual capacity ward.	Identify opportunities to maximise use of existing resources.
5	Service	Patients are not supportive of virtual care model	Obtain patient feedback about benefits and challenges from virtual ward care through feedback questionnaires; arrange in depth interviews with cohort of patients to explore challenges experienced using remote technology.
6	Service	Cannot track the benefits realised, leading to project de-prioritisation if short term return on investment cannot be proved	Build evaluation and benefits measurement into the project from the start; ensure a strong and compelling line of sight between project aims, investment objectives, business needs, anticipated benefits and the enablers and system features required to realise them.
7	Service	There is a risk that operational scalability may be limited due to local workforce challenges leading to partial outcome realisation and inconclusive model options.	The programme continuously evaluates the scalability of the service under a Scottish Borders context and will adjust staffing levels or allocation as needed to minimise any negative impacts to the integrity of the TOC.

8. CONSULTATION

Communities consulted

8.1. As early adopters of the Health and Social Care Partnership's Equality, Human Rights and Fairer Scotland Duty Impact Assessment process, the service has proactively identified several groups, paying specific attention to any gaps there may be.

8.2. The service will look to re-engage with identified group as well as others to understand the impact of integrated service.

8.3. The group are currently monitoring data through intelligence and feedback forms to proactively make changes where possible. Some of the groups that will be consulted previously included:

· Patient Representatives
· Physical Disability Group
· Strategic Ukrainian Settler Group
· Drug & Alcohol Partnership
· Poverty
· Ethnic Minority Group

Integration Joint Board Officers consulted

8.4. The IJB Chief Officer, Medical Director, Director of Nursing, Midwifery and AHPs and Director of Financial have been involved in scoping out a phase 2 proposal for Virtual Hospital and Home.

Approved by:

Laura Jones, Director of Quality and Improvement

Author(s)

Laura Jones, Director of Quality and Improvement

Background Papers: None included

For more information on this report, contact us at Deborah Raftery, Senior Project Manager – Deborah.raftery2@borders.scot.nhs.uk

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Scottish Borders Health and Social Care Partnership

Equality, Human Rights and Fairer Scotland Duty Impact Assessment – Stage 1 Proportionality and Relevance

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What Integration Joint Board (IJB) report or Partnership decision does this proportionality and relevance assessment relate to:

Development of Hospital at Home Service in the Scottish Borders

Relevant protected characteristics materially impacted, or potentially impacted, by proposals (employees, clients, customers, people using services) indicate all that apply

Age	Disability Learning Disability, Learning Difficulty, Mental Health, Physical Neurodiversity	Gender	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief (including non-belief)	Sexual Orientation
✓	✓	✓	✓			✓	✓	✓

Equality and Human Rights Measurement Framework – Reference those identified in Stage 1 (remove those that do not apply)

Education	**Work**	**Living Standards**	**Health**	**Justice and Personal Security**	**Participation**
Higher education Lifelong learning	Employment Earnings	Poverty Housing Social Care	Social Care Health outcomes Access to health care Mental health Reproductive and sexual health*	Hate crime, homicides and sexual/domestic abuse	Access to services Social and community cohesion* Family Life*

*Supplementary indicators

Main Impacts	**Are these impacts positive or negative or a combination of both**	**Are the impacts significant or insignificant?**
People will be cared for, as far as reasonably practicable, independently in their own home.	Positive	Significant
Improved patient satisfaction and health outcomes.	Positive	Significant
Prioritises the delivery of person-centered care in a respectful and dignified manner.	Positive	Significant

Is the proposal considered strategic under the Fairer Scotland Duty?	Yes
E&HRIA to be undertaken and submitted with the report – Yes **If no – please attach this form to the report being presented for sign off**	**Proportionality & Relevance Assessment undertaken by:** **Cathy Wilson – General Manager of P&CS** **Date: 10/05/23**

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Equality Human Rights and Fairer Scotland Duty Impact Assessment

Stage 2 Empowering People - Capturing their Views

Hospital at Home

The pilot will implement a Hospital at Home in NHS Border to understand how to gain the maximum benefits for the patients, how to assist with hospital pressures and how to implement the service so that it is operationally efficient- processes, procedures, sustainability.

Equality Human Rights and Fairer Scotland Impact Assessment Team

Role	Name	Job title	Date of IA Training
E&HR Service Specialist	TBD		
HSCP Joint Executive Team	Dr Lynn McCallum Chris Myers	Medical Director Chief Officer of Health and Social Care Partnership	
Responsible Officer	Cathy Wilson	General Manager – Primary and Community Services	
Main Stakeholder (NHS Borders)	Urgent and Unscheduled Programme Board		
Mains Stakeholder (SBC)	Urgent and Unscheduled Programme Board		
Third/Independent Sector Rep			
Service User	Margaret	Patient Representative	

	Carol Anderson	Patient Representative	

Evidence Gathering (will also influence and support consultation/engagement/community empowerment events)

Evidence Type	Source	What does the evidence tell you about the protected characteristics affected?
What equalities information is routinely collected from people currently using the service or affected by the policy?	Not currently gathered	New service equality data to be embedded, captured and reported against as part of TOC and will include the following Patient Management data systems – TRAK, EMIS, BadgerNet
Data on populations in need	Healthcare Improvement Scotland/Cochrane Review	Older people with frailty are the single biggest users of hospital beds and the fastest growing demographic. Across the UK the population of over-85s is predicted to double between 2018 and 2043. Evidence and experience points to various drivers for developing a Hospital at Home service for older people. Safe and effective alternatives to hospital bed-based acute care are needed to manage demographic pressures and provide a better experience for individuals.
Data on relevant protected characteristic	Not currently gathered	New service equality data to be embedded, captured and reported against as part of TOC and will include the following Patient Management data systems – TRAK, EMIS, BadgerNet
Data on service uptake/access	To be gathered via Hospital at Home Dashboard	New service equality data to be embedded, captured and reported against as part of TOC. This will include: Age Sex Race
Data on socio economic disadvantage	Not currently gathered locally. Healthcare Improvement Scotland	GP referral will be recorded to identify correlation between areas of multiple deprivation and access/uptake to the service. Nationally, areas of deprivation may have higher referral rates to Hospital at Home services. COVID-19 has seen a shift towards patients requesting an alternative to hospital admission and may increase referral rates. Patients living in rural areas where it could be difficult to access medical care could see Hospital at Home as a favourable option.

Research/literature evidence	Healthcare Improvement Scotland/Cochrane Review	Evidence points to various drivers for developing a Hospital at Home service for older people as it reduces the disruption to a person's existing formal and informal care and support arrangements through the addition of acute-level care in their home. The drive to provide a more person-centred care experience for individuals, avoiding the risks of healthcare acquired infection, and/or institutionalisation.
Existing experiences of service information	Not available - new service to Scottish Borders	Not available - new service to Scottish Borders
Evidence of unmet need	NHSB delayed discharge data	Scottish Borders has the largest percentage of people going from hospital to residential care as unable to meet their needs within the community.
Good practice guidelines	Hospital at Home – Healthcare Improvement Scotland	Evidence points to various drivers for developing a Hospital at Home service for older people as it reduces the disruption to a person's existing formal and informal care and support arrangements through the addition of acute-level care in their home. The drive to provide a more person-centred care experience for individuals, avoiding the risks of healthcare acquired infection, and/or institutionalisation.
Other – please specify		
Risks Identified		Not identified yet as still to find out what the inequalities are
Additional evidence required		

Consultation/Engagement/Community Empowerment Events

Event 1: Patient Representative Discussion

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
28/02/2023 - onward	Teams	2	Age, Poverty, Disability, Unpaid careers

***Attendance by category – including but not limited to: People using the service, people not using the service - currently, unpaid carers, paid carers, key stakeholders (organisation and job title)**

Views Expressed	Officer Response
Patient representatives asked for alternative forms of gathering patient feedback once the service has been implemented. An example given would be exploring the potential for volunteers to gather feedback from patients either online or on paper.	Patient feedback forms to be co-designed with patient representatives.
Under Living Standards, should people living alone, with no family member close by, be included?	Living alone does not exclude anyone from being eligible for Hospital at Home – everyone irrespective of if they live alone or with someone will be assessed against the eligibility criteria.

Event 2: Strategic Ukrainian Settler Group

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
18/04/2023	Teams	Not documented	Age, Race, Religion/Belief, Refugees

Views Expressed	Officer Response
Language Barriers Question raised from Ukrainian Settler Group on how HAH will overcome language barriers when treating patients.	Establish at initial assessment how person would like to be communicated with. This will enable HAH team to follow the same procedure as in hospital. They will utilise services such as Language Line, Say Hi, Google Translate. Protocols around the use of language apps etc to be developed to reduce any possibility of data breach or misinformation. Patient feedback forms will look to capture satisfaction of the process.

Event 3: Physical Disability Strategy Group

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
13/04/2023	Teams	Not documented	Disability

Views Expressed	Officer Response
What if I need additional equipment? What happens if I need a hoist? What if a patient has complex needs?	This was taken into discussion with the Physical Disability Strategy Group and resulted in the co-production of a contribution to the Hospital at Home Information Pack which addresses all of the questions asked

Event 4: Alcohol and Drug Partnership

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
24/04/2023	Teams	Not documented	Substance/ alcohol misuse

Views Expressed	Officer Response
No view expressed at this involvement event.	Link between Hospital at Home Programme Board and the Alcohol and Drug Partnership to enable ongoing dialogue during the TOC to ensure the needs of those with the relevant lived experience are taken into account.

Event 5: NHSB Ethnic Minority Group **

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
26/04/2023	Teams	Not Recorded	Race

Views Expressed	Officer Response
A positive development that enables individuals to meet their own cultural needs eg food preparation	

Equality, Human Rights and Fairer Scotland Duty Impact Assessment

Stage 3

Analysis of findings and recommendations

Hospital at Home

Please detail a summary of the purpose of the proposal being developed or reviewed including the aims, objectives and intended outcomes

In recent years, healthcare professionals have been considering new ways to respond to the acute care needs of older people with frailty and other long-term conditions. Urgent care is needed but hospitals bring risks for older people as well as benefits, and community-based alternatives are increasingly being explored. This has resulted in a shift in focus within the NHS and internationally towards providing hospital-level care in a person's home environment. This service is generally referred to as "Hospital at Home" and is a short-term intervention providing acute care of a level comparable with that provided in a conventional hospital. It is not the same as case management of chronic conditions but can work with this type of service to assist in the management of exacerbations of those conditions.

Across Scotland, Health Boards have developed this service to provide care in this form. The care is recognised to be safe and cost effective, and popular with patients and staff. It can provide an alternative to admission for selected patients and (once scaled up) can relieve some pressure on acute services, though only in some areas has it been shown to facilitate closure of inpatient beds.

The pilot will implement a Hospital at Home in NHS Border to understand how to gain the maximum benefits for the patients, how to assist with hospital pressures and how to implement the service so that it is operationally efficient- processes, procedures, sustainability.

Section 1: Equality Act 2010 – Relevant Protected Characteristics as identified in Stage 1 or during Stage 2

Protected Characteristic	Equality Duty	What impact and or difference will the proposal have	Measures to evaluate/mitigating actions
Age	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home is uniquely designed and planned with a person-centred approach. Hospital at Home assessments takes into account individual preferences, capabilities, and independence. Therefore ensuring that people are treated with dignity and respect.	Hospital at Home reporting dashboard monitors admission by age.
	Advancing equality of opportunity	Hospital at Home assessments criteria will ensure that the care package is designed to meet the unique requirements of each individual, enabling older people to live in their own home with their loved ones.	Hospital at Home reporting dashboard monitors admission by age. Analysis of patient feedback forms.
	Fostering good relations by reducing prejudice and promoting understanding	Hospital at Home associated communication leaflets have been designed to promote that this service is designed to meet needs and not explicitly for people over the age 65+.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases.
Disability	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home is an inclusive service, that results in a more tailored service for patients because of reasonable adjustments and taking an agile/flexible approach to patient care.	Ensure our Patient Management System is up to date with knowledge about patient communication needs and capacities. It is not possible with the current data set to clearly capture and report on individuals with disabilities, however case notes and be reviewed retrospectively and daily huddles discussions include the review of

		For people with disabilities, long-term conditions, or frailty, Hospital at Home offers several benefits. Patients can maintain their independence by living in familiar surroundings, where they have established support networks and access to community resources. This helps to preserve their sense of identify and autonomy while receiving the necessary care and assistance tailored to their specific needs.	individual care – recognise each patient care and/or enhanced care needs
	Advancing equality of opportunity	Allowing individuals to be treated in the comfort of their own home environment which may be a more appropriate and familiar setting, Hospital at Home complements the person-centred approach. The Hospital at Home model of care provides the time to go over key information to help people with learning disabilities to make informed decisions.	We will engage with learning disability groups within the local community to ensure that people with learning disabilities are aware of what the Hospital at Home service is.
	Fostering good relations by reducing prejudice and promoting understanding	Hospital at Home associated communication leaflets have been designed to promote that this service is designed to meet needs including those of disabled people.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases.
Gender Reassignment	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	By supporting people at home, the service can be beneficial to those who feel any perceived risks as a result of gender	We will link with Gender Reassignment groups to understand what adjustments

		reassignment by providing the flexibility to schedule appointments or access healthcare.	may be required and we will train our staff to be aware of these. Investigating if our Patient Management System can support gender identification and use of pronouns
	Advancing equality of opportunity	Being in a familiar environment can reduce stress and contribute to a sense of safety	We will listen to our community representatives and the voices of those with lived experience to ensure our services meet the needs of people undergoing gender reassignment recognising that they may require service adjustments sensitive to these.
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this time	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases. Staff and caregivers will be trained on appropriate use of pronouns and questions through training.
Marriage and Civil Partnership	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at this stage	None identified at this stage

	Advancing equality of opportunity	None identified at this stage	None identified at this stage
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this stage	None identified at this stage
Pregnancy and Maternity	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at this stage	None identified at this stage
	Advancing equality of opportunity	None identified at this stage	None identified at this stage
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this stage	None identified at this stage
Race	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home care delivery will be designed to meet the specific medication and care needs of individuals.	Ensuring communication and information is available in different languages.
	Advancing equality of opportunity		Staff will be made aware of the sensitivities relating to explaining some health issues, for example, mental health issues or sexual health issues.
	Fostering good relations by reducing prejudice and promoting understanding		We will listen to our community representatives and the voices of those with lived experience to ensure our services meet the individual needs of people recognising that some Races have a higher incidence of certain diseases.
Religion & Belief including non-belief	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Individuals will co-produce a care plan that meets their religious requirements e.g. times of worship, religious-based dietary requirements, cultural awareness and sensitives e.g., providing hygienic shoe covers to enable entry to house	Staff awareness programme

	Advancing equality of opportunity	Hospital at Home enables individuals to continue practice more fully their religious beliefs.	None identified
	Fostering good relations by reducing prejudice and promoting understanding	We will listen to our community representatives and the voices of those with lived experience to ensure our services meet the needs of people regardless of religion and belief.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases. We will link with representatives of the relevant religious and faith communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect. Hospital at Home staff are trained to have cultural competence, compassion, and sensitivity, ensuring that care is provided in a respectful and non-discriminatory manner. This helps foster trust and a positive relationship between the patient and their care providers.
Gender (Sex)	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home enables the individual to present in their preferred gender and not to conform with hospital admission criteria.	Investigating if our Patient Management System can support gender identification and use of pronouns
	Advancing equality of opportunity	Hospital at Home enables the individual to present in their preferred gender and not to conform with hospital admission criteria.	Staff will be made aware of the sensitivities surrounding gender

			Analysis of patient feedback forms.
	Fostering good relations by reducing prejudice and promoting understanding	Individuals will co-produce a care plan that recognises their gender preferences and document sensitives around care giving.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases
Sexual Orientation	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at this stage	We are still to meet with representatives of the LGBTQ+ communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.
	Advancing equality of opportunity	None identified at this stage	We are still to meet with representatives of the LGBTQ+ communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this stage	We are still to meet with representatives of the LGBTQ+ communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.

Section 2: Equality and Human Rights Measurement Framework Human– Reference those identified in Stage 1 (remove those that do not apply)

Domain	Indicator	Enhancing or Infringing	Impact and or difference will the proposal have	Measures to evaluate/mitigating actions
Education	Higher education and lifelong learning	Enhancing	The proposal will allow those to continue attendance of education without unnecessary interruption. It allows them to receive necessary medical care while still being able to attend classes or study from home. Enables individuals with disabilities or chronic illnesses to actively participate in higher education or lifelong learning. They would not be restricted to the physical limitations of hospital settings, promoting inclusion and equal opportunities for education. Patients can engage in educational activities at their own pace and convenience, preserving their dignity and autonomy throughout the treatment process. Overall, the flexibility of the service empowers patients to balance their educational commitments and medical treatment effectively.	Feedback from patients will focus on accessibility, inclusivity, autonomy, and flexibility that the service has offered.
Work	Employment Earnings	Enhancing	The proposal will allow people who work from receive necessary medical care while still being able to work. This empowers patients to balance work/life commitments and medical treatment effectively.	Feedback from patients will focus on accessibility, inclusivity, autonomy, and flexibility that the service has offered.

		Infringing	An unpaid carer in paid employment may be negatively affected if they are required to support the patient at home while treatment is provided.	Part of the assessment for Hospital at Home eligibility is a conversation with the individual, family and/or non-paid carer. It is important prior to admission to fully understand the impacts treatment in a home may have.
Living Standards	Poverty Housing Social Care	Enhancing	Enables people to stay at home to. The service will also be able to signpost and refer people they are caring for to community based services.	We will ensure safeguarding is in place such as researching into how food is provided to patients who need it prior to referring a patient to the Hospital at Home service. We will work with other community services such as social work to ensure patients are able to access the Hospital at Home service. We will utilise the Integrated Joint Board needs assessment to understand the needs of patient. We will tap into poverty related third sector to support patients access care in their homes. We will aim to deliver person-centred service in response to need.

				Hospital at Home is aware of possible fluid accommodation arrangements so the Hospital at Home service will develop a way of being flexible to meet the needs of potential patients, especially as patients may be in non-residential setting eg hotels
Health	Social Care Health outcomes Access to health care Mental health	Enhancing Infringing	By enabling individuals to remain in their homes or community settings, Hospital at Home helps minimise the disruption and negative impact associated with institutional care. This can lead to improved mental wellbeing, reduced stress, and enhanced social connections, as individuals are able to maintain their social interactions and engagement within their communities. The majority of unpaid carers are women and by using Hospital at Home will enable women to continue in their care-giving role Non-paid carers that may benefit from temporary respite from an acute hospital stay, may be negatively impacted by having to look after their loved ones at home.	Staff who are treating patients in their home will be able to signpost to appropriate community support services provided by third sector. Admission with no onward referral to inpatient services Through patient feedback surveys that Hospital at Home staff provide during visits.
Justice and Personal Security	Hate crime, homicides and sexual/domestic abuse	Enhancing	Hospital at Home may provide a service in a setting that has domestic abuse which may endanger the patients themselves or the non-paid carer in their home. Quality and ability of the service may also be impacted. As nurses are trained to recognize signs of domestic	We will ensure safeguards are in place for patients/ respond quickly if any gender-based violence occurs.

			abuse in the home, they will be able to raise concerns via the adult protection process.	Safer community documents are shared from community groups.
Participation	Access to services Social and community cohesion* Family Life*	Enhancing	By enabling individuals to remain in their homes or community settings, Hospital at Home helps minimise the disruption and negative impact associated with institutional care. This can lead to improved mental wellbeing, reduced stress, and enhanced social connections, as individuals are able to maintain their social interactions and engagement within their communities.	Through patient feedback surveys that Hospital at Home staff provide during visits.

Section 3: Fairer Scotland Duty

Identify changes to the strategic programme/proposal/decision to be made to reduce negative impacts on equality of outcome and or improving health inequalities	Updating Information Pack's Q&A with additional details around accessing equipment Recognising the cultural and religious sensitivity aspects of treating a patient in their home through training As the proposal is in a test to change cycle for an additional 6 months the team will be constantly reviewing and assessing changes that can be made to reduce impact and improve health inequalities.
Identify the opportunities the strategic programme/proposal/decision provides to reduce or further reduce inequalities of outcome and or improving health inequalities	Hospital at Home can enhance access to health care for patients who may face barriers such as transportation difficulties, socioeconomic challenges, or living in remote areas. By bring the necessary care directly to patients' homes, Hospital at Home can bridge the gap an ensure equitable access for all individuals, reducing inequalities in outcomes. Hospital at Home enables clinicians/ health care professionals to intervene promptly when patients' conditions require medical attention. This timely intervention can prevent exacerbation of illnesses and reduce the likelihood of complications, improving health outcomes and narrowing health inequalities caused by delayed or inadequate treatment.

	Care is tailored to individual needs. This approach can address health inequalities by acknowledging and accommodating patients' specific circumstances, cultural backgrounds, and preferences. Carers don't have to travel to hospital and care packages will remain the same for patients. Hospital at Home service facilitate better continuity of care by enhancing communication and coordination between health and social care providers, leading to more streamlined and holistic care – this is particularly important for those with complex medical conditions or multiple health care needs, reducing health inequalities. By providing patients with information, resources, and support to manage their conditions effectively, the services can empower individuals to take control of their health, reducing health inequalities associated with knowledge gaps or limited literacy.

Section 4: Are there any negative impacts with no identified mitigating actions? If yes, please detail these below:

Not Applicable

Section 5: Equality, Human Rights & Fairer Scotland Duty Impact Assessment Recommendations

What recommendations were identified during the impact assessment process:

Recommendation	Recommendation owned by:	Date recommendation will be implemented by	Review Date
	(Name and job title)		
Analysing feedback forms to gather relevant information under Fairly Scotland Duty	Cathy Wilson, GM	31/01/2024	TBD after evaluation of TOC
Review easy read material – adapted from learning from Hospital at Home pilot	Cathy Wilson, GM	31/01/2024	TBD after evaluation of TOC
Staff training on cultural and social sensitivities	Hospital at Home Clinical Team Lead	31/01/2024	TBD after evaluation of TOC
Establish list of community services for signposting	Hospital at Home Administrator	31/01/2024	TBD after evaluation of TOC
Codesign patient leaflet	Hospital at Home Clinical Team Lead	31/01/2024	TBD after evaluation of TOC
Investigation Patient Management system for recording of additional characteristics	Hospital at Home Administrator	31/01/2024	TBD after evaluation of TOC
Continuing active engagement with representatives of LGBTQA+; religious and faith, Race and people undergoing gender reassignment	Cathy Wilson, GM	31/01/2024	TBD after evaluation of TOC

Section 6: Monitoring Impact – Internal Verification of Outcomes

How will you monitor the impact this proposal affects different groups, including people with protected characteristics?

Monthly Hospital at Home Reporting Sub-Group Analysis of data to see if there are any variances between the protected characteristics Through patient feedback surveys that Hospital at Home staff provide during visits Continuous engagement with community representatives to gather feedback to help inform our thinking and develop our service

Section 7: Procured, Tendered or Commissioned Services (SSPSED)

Is any par/t of this policy/service to be carried out wholly or partly by contactors and if so, how will equality, human rights including children's rights and the Fairer Scotland duties be addressed?

No

Section 8: Communication Plan (SSPSED)

Please provide a summary of the communication plan which details how the information about this policy/service to young people, those with a visual or hearing sensory impairment, difficulty with reading or numbers, learning difficulties or English as a second language will be communicated.

Our Public Health team has recently joined us for collaborative working to ensure that any communication plans are communicated in a way that supports young people, those with a visual or hearing sensory impairment, difficulty with reading or numbers, learning difficulties or English as a second language. Easy read material will be provided for those who request it and communication awareness with staff to understand the challenges.

Signed Off By:

Cathy Wilson, General Manager of Primary and Community Services

Date: 13/09/23

HEALTH & SOCIAL CARE PARTNERSHIP

Community Hospitals Review

Scottish Borders
Health and Social Care
PARTNERSHIP

Phase 1: Medical cover review

- Short term review of Community Hospital medical cover from the end of March 2024 for the Knoll and Kelso Community Hospitals has identified a model that is now being progressed:
    - The chosen model is to share BGH Consultant(s) to support Kelso and Knoll Community Hospitals, while utilising the newly employed Advanced Nurse Practitioner to cover both sites

Scottish Borders
Health and Social Care
PARTNERSHIP

Phase 2

- Planning for the next phase of the work associated to the IJB Direction is being scoped

- In this phase, a model will be defined that is fit for the future is developed closely aligned with the needs of patients in Community Hospitals, and the objectives and ways of working outlined in our Health and Social Care Strategic Framework

Scottish Borders
Health and Social Care
PARTNERSHIP

Why review?

- People in hospital who do not need hospital care have poorer outcomes

- As of 13th March - 42 people across hospitals are waiting for care (46% of Hospital Occupancy):
    - Long-Term Care; or
    - Package of Care

  and could be more appropriately cared for in an alternative setting, if we were able to provide these more appropriate services

- 3 of our 4 Community Hospitals would require major building and refurbishment work to make them fit for the future needs of our patients

Scottish Borders
Health and Social Care
PARTNERSHIP

Why review?

- Very challenging financial context

- Impacts of rurality on service provision – higher demand, smaller health and social care workforce supply, more travel, etc.

- Medical workforce sustainability in General Practice, which impact on the medical cover for Community Hospitals and core activity within General Practices

Phase 2 review approach

- Understanding the data
- Considering alignment to our Strategic Framework
- Undertaking consultation with patients, staff and those with protected characteristics under phase 1 and starting phase 2 of the Integrated Impact Assessment
- Understanding constraints
- Making recommendations on the future model of service delivery that meets needs and is fit for the future

Scottish Borders
Health and Social Care
PARTNERSHIP

Ways of working

- HSCP ways of working will apply throughout
- Close working with Staff, Staff Partnership colleagues, Unions, Patients, Partners, Communities, Elected Members
- Risk to be proactively managed throughout the process
- Work will be aligned to the integration planning and delivery principles

Scottish Borders
Health and Social Care
PARTNERSHIP

Timeline

March – June 2024	• **Design & Plan** - Community Hospitals Data gathering and analysis -Potential patient types / pathways and numbers • Conclude on the number type of beds required in each locality • Consider interaction/opportunities with other HSCP Transformation work • 2024 dates for DOCA self-assessment: 27/28/29 Feb 24 • Kelso / Knoll move to new interim medical status from 01/04/24 • Submit Review report with recommendations to IJB for decision • On going, timely and consistent staff communication

Timeline

July – Oct 2024	• **Consult & Engage** • Sustained staff engagement • 12-week public engagement

Scottish Borders
Health and Social Care
PARTNERSHIP

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Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 March 2024

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Report by Dr Sohail Bhatti, Director of Public Health

1. PURPOSE AND SUMMARY

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

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) Note the report.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
		X		X	X

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
X	X				X

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required.

5. BACKGROUND

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

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

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

6. IMPACTS

Community Health and Wellbeing Outcomes

6.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	X
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	X
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	X
5	Health and social care services contribute to reducing health inequalities.	X
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	
7	People who use health and social care services are safe from harm.	
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	
9	Resources are used effectively and efficiently in the provision of health and social care services.	

Financial impacts

6.1 N/A.

Equality, Human Rights and Fairer Scotland Duty

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

Legislative considerations

6.3. N/A.

Climate Change and Sustainability

6.4. N/A.

Risk and Mitigations

6.5. N/A.

7. CONSULTATION

Communities consulted

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

Integration Joint Board Officers consulted

7.2 IJB Chief Officer.

Approved by:

Dr Sohail Bhatti, Director of Public Health

Author(s)

Dr Sohail Bhatti, Director of Public Health

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

Previous Minute Reference: N/A

For more information on this report, contact us at Dr Sohail Bhatti, Sohail.bhatti@borders.scot.nhs.uk

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REAL ACTION FOR PREVENTION:

a vision of population health in the Scottish Borders

Report of the Director of Public Health 2023
NHS Borders

NHS Borders

FOREWARD

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

The report is in two sections:

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

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

  These reports specifically are:

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

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

Dr Sohail S Bhatti
Director of Public Health
NHS Borders

CONTENTS

The Case for Prevention in Acute Times

What is prevention?

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

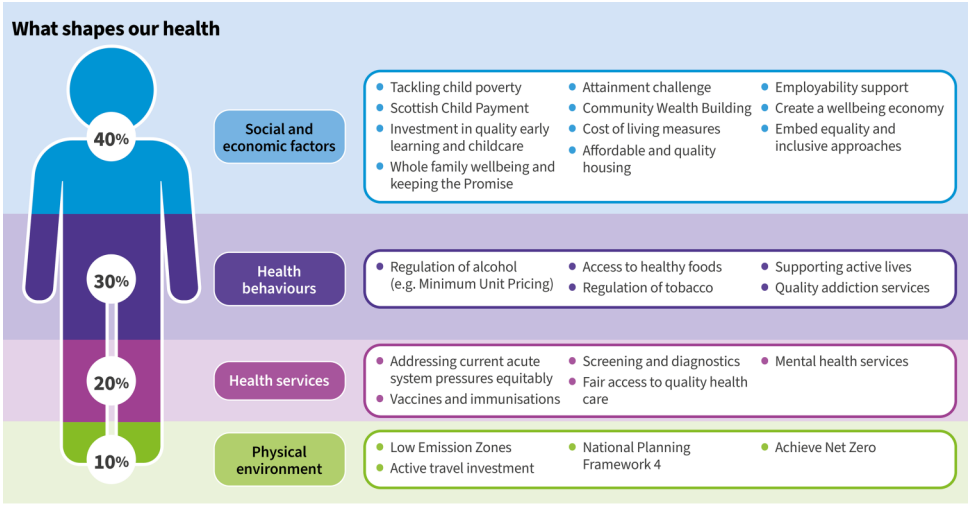
Primary prevention is where action is being taken to stop a condition, disease or illness ever occurring within an individual who is at risk. The target group is usually healthy people who are free of the issue in question but who have associated risk factors. Examples of primary prevention include immunising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

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

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

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

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



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

Source: Public Health Scotland

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

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

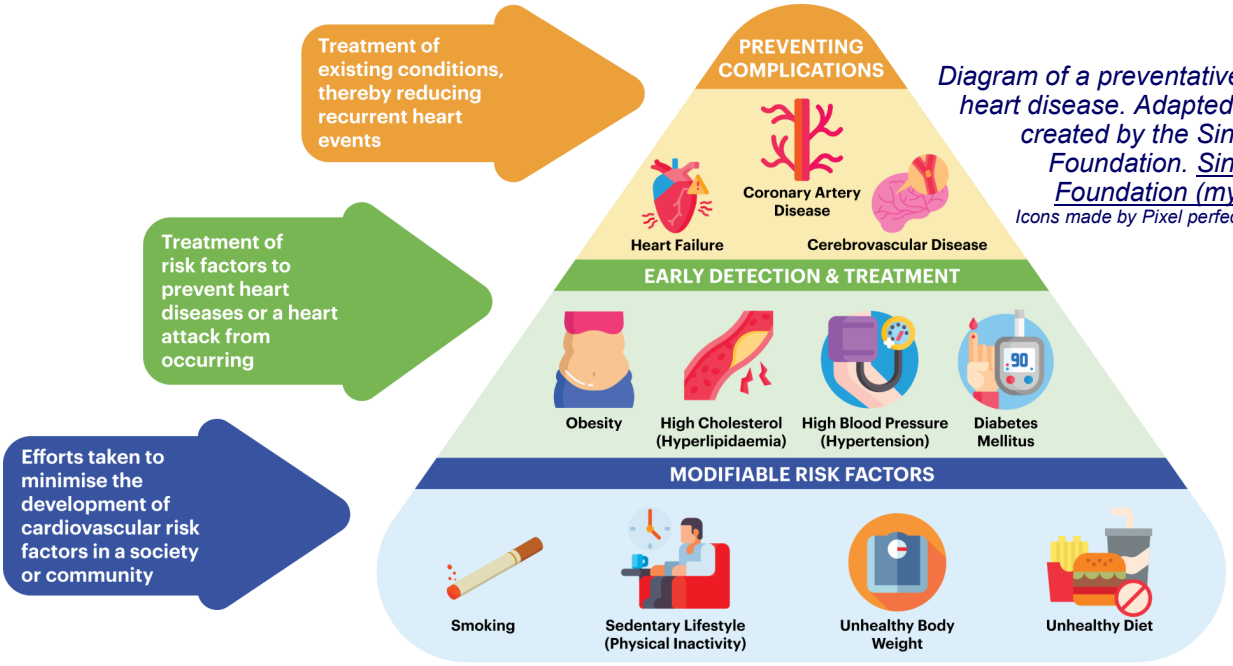


Diagram of a preventative approach to heart disease. Adapted from a figure created by the Singapore Heart Foundation. Singapore Heart Foundation (myheart.org.sg)
Icons made by Pixel perfect and Freepik from www.flaticon.com

Evidence for a preventive approach

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

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

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

What is a QALY?

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

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

Here's how the calculation works:

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

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

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

Scottish burden of disease

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

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

Primary prevention first

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

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

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

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

Mobilising a preventative system across Scottish Borders

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

Prevention in healthcare

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

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

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

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

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

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

What is Social Prescribing?

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

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

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

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

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

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

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

What is ALISS?

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

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

For in-patient and out-patient services

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

For our staff (and their families, when appropriate)

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

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

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

Prevention interventions in social and community care

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

For social care

As employer/commissioner

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

For the client group

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

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

Partnerships and community development

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

Source: Dahlgren and Whitehead (1991)

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

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

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

Partner institutions

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

Primary Prevention

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

Secondary Prevention

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

Tertiary Prevention

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

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

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

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

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

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

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

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

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

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

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

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

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

Communications and community engagement

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

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

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

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

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

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

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

Evaluation and monitoring

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

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

Environment: flooding and climate adaptions

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

Local activity

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

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

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

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

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

Conclusions and recommendations

Conclusions

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

Recommendations

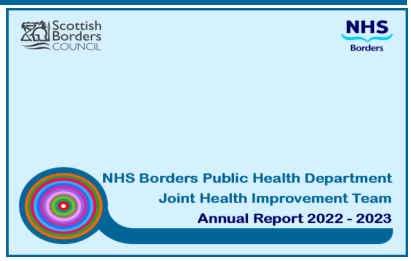
1. We need a **strong leadership focus on Prevention**, and this needs to be connected to mainstream work within the NHS Board. An indicative ring-fenced budget, no matter how small in the early years, will galvanise interest and action, and could act as a catalyst for change. Working collaboratively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

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

Public Health Activity in Scottish Borders 2023

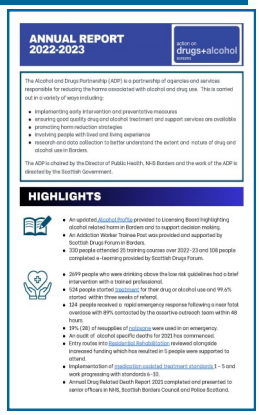
JHIT Annual Report

Attachment 1



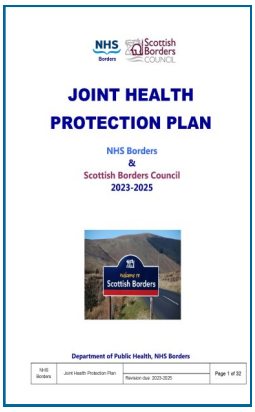
ADP Highlight Annual Report

Attachment 2



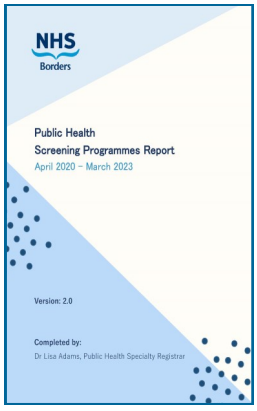
Joint Health Protection Plan

Attachment 3



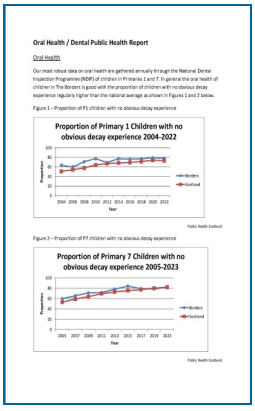
Screening Programmes Report

Attachment 4



Oral Health Report

Attachment 5



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

Joint Health Improvement Team

Annual Report 2022 - 2023

Contents

Introduction

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

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

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

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

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

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

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

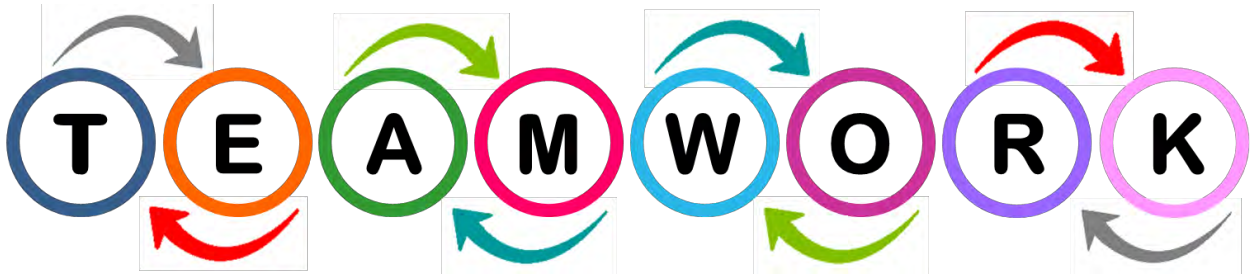
JHIT is part of NHS Borders Public Health Department and the staff team includes members from both NHS Borders and Scottish Borders Council.

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

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

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

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



Public Health Priorities for Scotland

Public Health Priorities

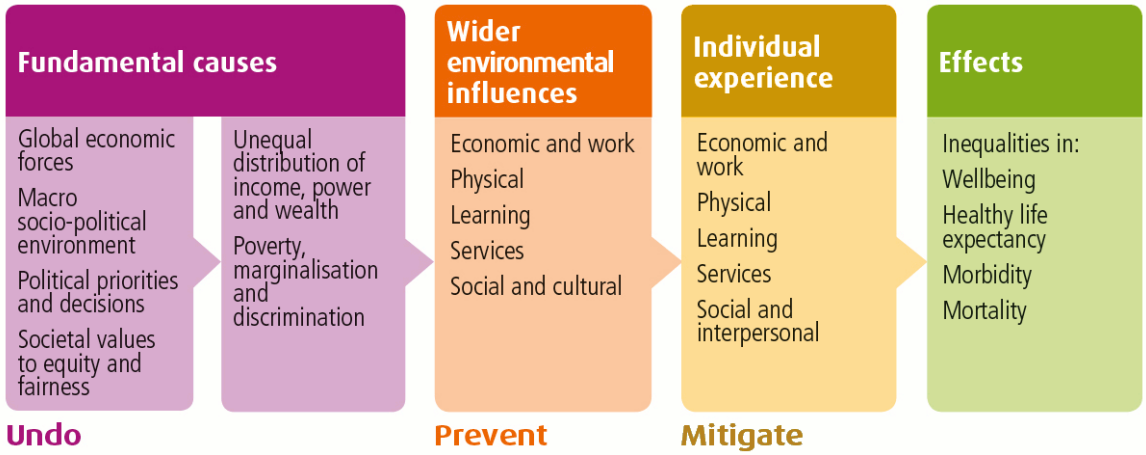
The Scottish Government has agreed a clear set of related and inter-dependent priorities for Scotland which are:

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

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

Public Health Scotland

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



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

Activities Overview and Data

Money Worries App

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

Walk It

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

Fit4Fun Families

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

Healthy Start Vitamins

- Women's **1399**

Vitamin D

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

Quit Your Way (Apr - Jan 23)

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

Data for 40% most deprived areas in Borders

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

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

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

Breastfeeding in the Borders (BiBs)

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

Wellbeing Service

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

Community Food Work

- Reached **349** families

JHIT Training

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

Training and Capacity Building

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

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

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

Training and Capacity Building

Children, Young People and Families Training Highlights

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

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

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

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

Communicating with Our Public

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

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

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

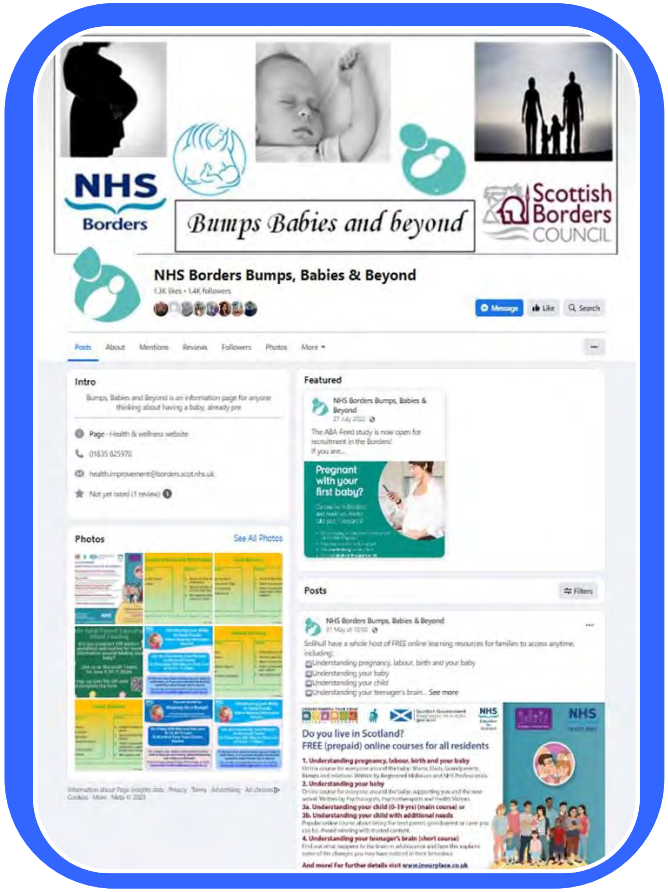
So far in 2023 the best received posts in terms of reach on Small Changes Big Difference were in relation to this period mental health, suicide prevention, food and health and cost of living.

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

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

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

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



Priority 1

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

Whole Systems Approach (WSA) Eyemouth

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

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

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

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

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

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

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

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

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

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

Priority 1

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

Highlights of Whole Systems Approach

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

Reflections

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

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

Links to other resources and reports:

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

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

Priority 1

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

Community Justice Greenhouse Project

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

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

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

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

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

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

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

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

Priority 2

A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Free Vitamins Distribution

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

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

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

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

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

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

Priority 2

A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Children's Rights

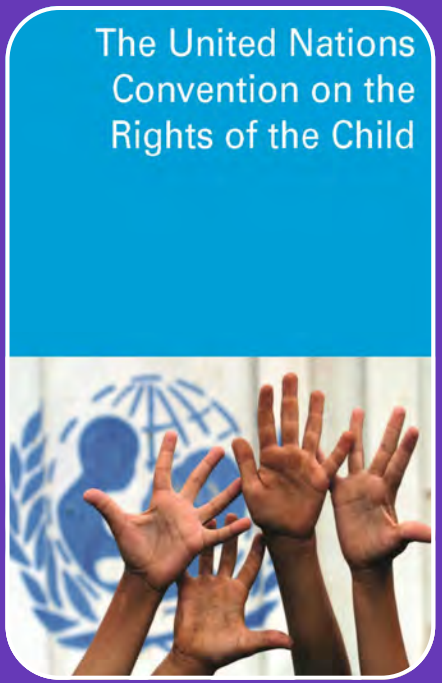
JHIT is committed to ensure all children, young people and their families have their rights valued, realised, protected and respected.

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

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

UNCRC Article 12

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



Priority 2

A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Breastfeeding in the Borders (BiBs)

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

BiBs Breastfeeding in the Borders

Support is offered in the following areas:

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

Discharge Rota

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

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

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

Participants Feedback

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

"Grateful for my HV who recommend BiBs"

"Incredibly supportive service"

Local Groups

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

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

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

Maternity Ward

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

Priority 2

A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Breastfeeding Friendly Scotland

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

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

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

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

ABA Feed Research Trial

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

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

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

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

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

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

Mental Health Improvement and Suicide Prevention

Adults Mental Health Improvement and Suicide Prevention

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

The four programme areas identified:

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

Work that has informed some of these programme areas include:

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

Communication, Engagement and Awareness Raising

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

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

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

Targeted Communities

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

Adult Communities Mental Health and Wellbeing Funding

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

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

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

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

Our Outcomes

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

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

New Services

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

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

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

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

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

New developments

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

Priority 4

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

Jenny and the Bear

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

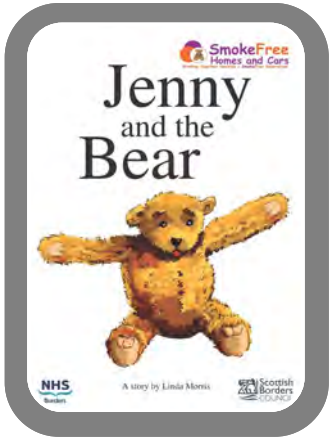
Children breathe faster than adults, which means they take in more of the harmful chemicals in second-hand smoke. They're even more sensitive to smoke than adults because their bodies are young and still developing. Research shows that babies and children exposed to a smoky atmosphere are likely to have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

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

There is also an increased risk of developing:

- Bacterial meningitis
- Bronchitis
- Pneumonia
- Acute respiratory illnesses

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



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

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

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

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

Priority 4

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

Wellbeing Service

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

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

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

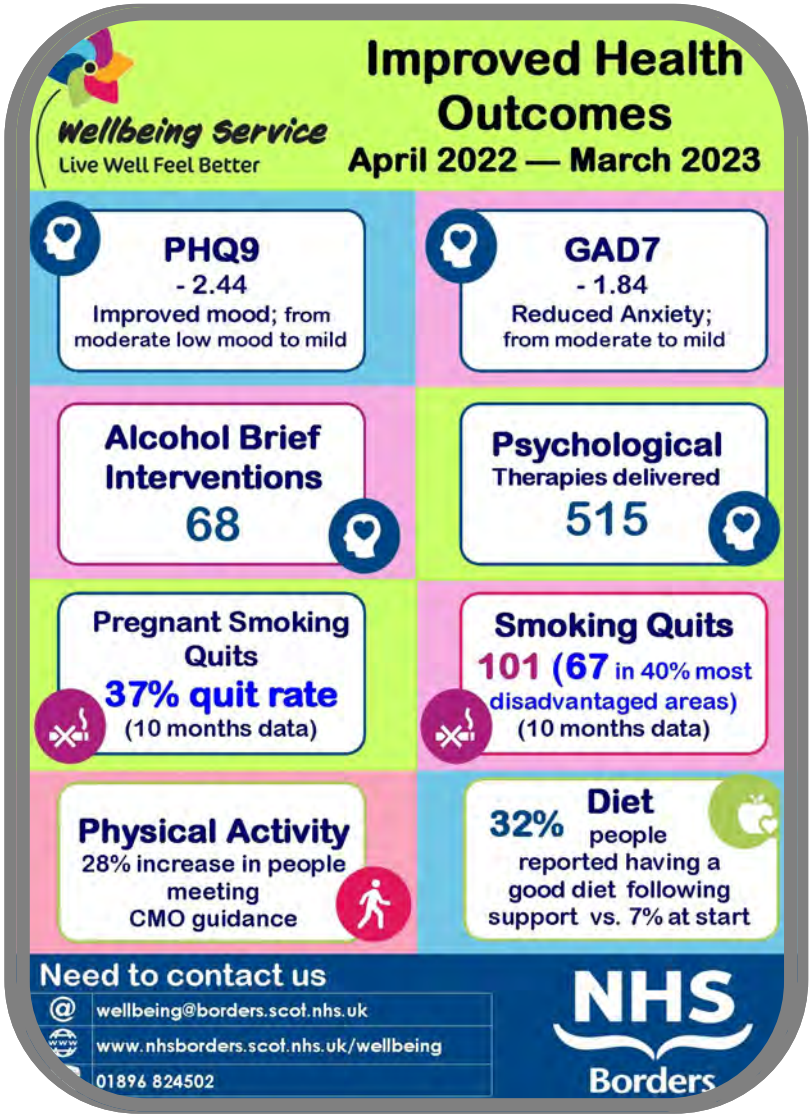
Referrals

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

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

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

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



Priority 4

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

Care Opinion

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

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

Smoking Cessation

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

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

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

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

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

Priority 4

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

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

Wider Work

Service involvement in 2022 - 2023 projects:

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

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

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

Wellbeing Service Feedback

Annual summary 2022 - 2023

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

Priority 5

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

NHS Borders Money Worries App

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

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

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

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

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

Training insights during 2021 - 2022 confirmed

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

Priority 5

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

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

Participant Feedback

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

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

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

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

Download the App

GET IT ON Google Play

Download on the App Store

Priority 5

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

Low and Slow Project

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

Project Aims

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

Objectives

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

Rollout of Project

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

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

Projects Have

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

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

Case Study

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

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

Priority 6

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

Borders Child Healthy Weight Service

Fit4Fun Families

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

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

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

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

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

Family Quote

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

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

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

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

Scottish Borders
Fit4Fun Families

Priority 6

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

Paths to Health - Walk It

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

Objectives

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

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

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

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

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

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

walkit
walk your way to health & happiness

Priority 6

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

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

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

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

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

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

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

Participants Feedback

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

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

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

Participant feedback

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

"I really enjoyed cooking together and meeting other parents"

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

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

Priority 6

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

Langlee Breakfast, Bumps, Babies and Toddlers Group

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

Aims and Objectives

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

What We Did

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

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

Participants Feedback

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

"Helped my anxiety and mental health"

Next Steps

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

Looking Forward / Next Steps

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

Mental Health Improvement/ Suicide Prevention

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

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

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

Supporting NHS Borders Staff Wellbeing Week.

Eating Well and Staying Active

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

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

Looking Forward / Next Steps

Children's Rights and Delivering the Promise

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

Organisational Development

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

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

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

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

Need to contact us

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

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

☎ 01835 825970

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ANNUAL REPORT 2022-2023

action on drugs+alcohol BORDERS

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

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

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

HIGHLIGHTS

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

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

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

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

CHALLENGES

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

OUTCOMES

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

JOINT HEALTH PROTECTION PLAN

NHS Borders
&
Scottish Borders Council
2023-2025

Department of Public Health, NHS Borders

Table of Contents

1. Preface

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

1.1 Geographical extent of Plan

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

1.2 Statutory responsibility

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

1.3 Authors

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

1.4 Governance arrangements

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

1.5 Status

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

2. Overview of the Borders

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

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

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

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

3. The Public Health Act 2008

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

In summary the Act does the following:

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

4. Control of Communicable Disease in the Borders

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

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

5. Health Protection Planning Infrastructure

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

6. Emergency Planning

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

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

7. Collaborative arrangements

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

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

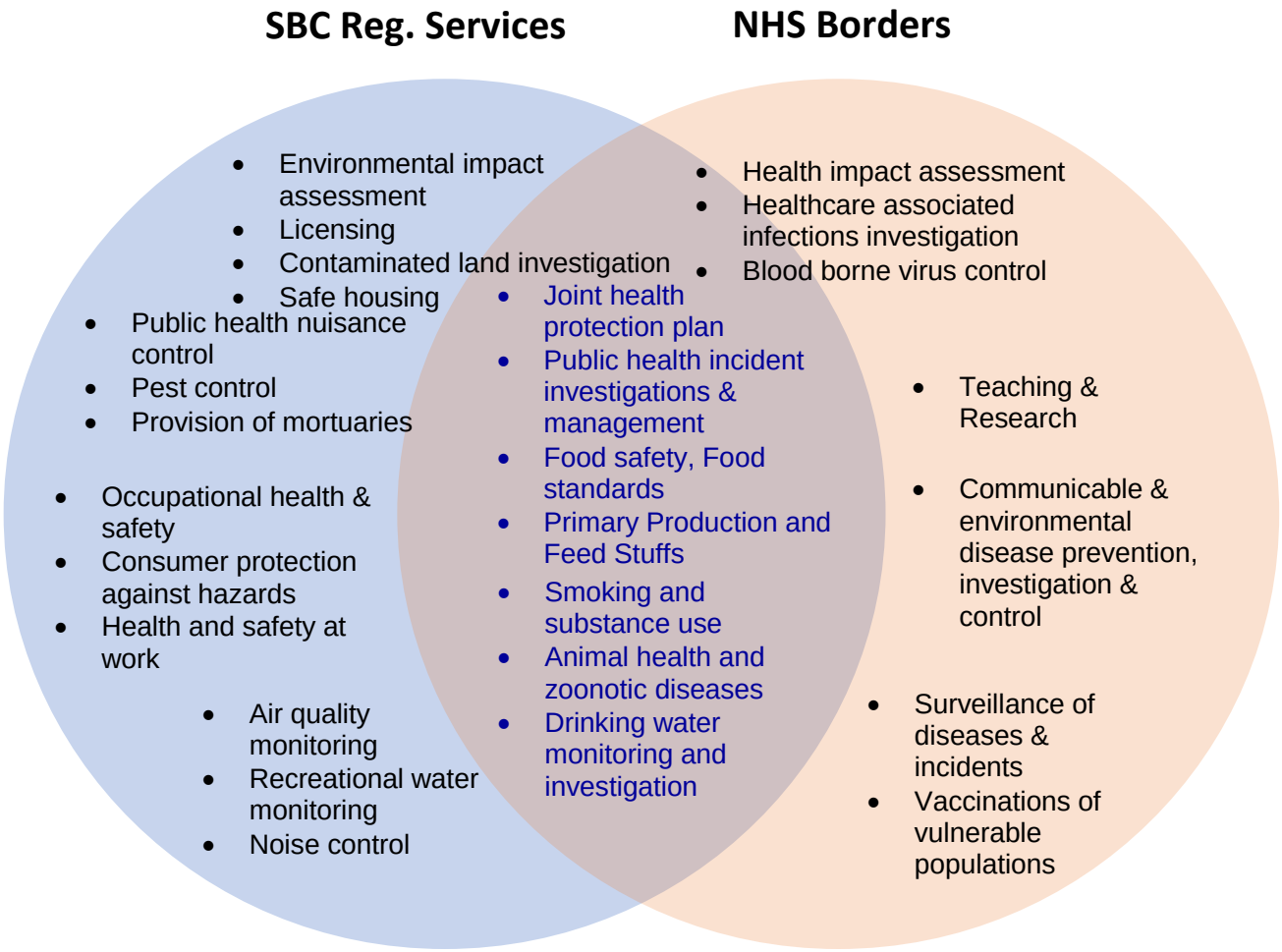

Figure 1: An illustrative summary of the joint working and areas of collaboration between NHS Borders and the SBC Regulatory Services

8. Resources and Operational Arrangements

8.1 Staffing

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

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

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

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

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

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

8.2 IT and Communications Technology

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

8.2.1 IT and Communications Technology available to NHS Borders

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

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

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

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

8.2.2 IT developments

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

8.2.3 IT and Communications Technology available to Scottish Borders Council

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

Guidance is available on:

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

8.3 Out of hours response arrangements

8.3.1 NHS Borders

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

8.3.2 Scottish Borders Council

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

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

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

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

8.5 Staff knowledge, skills and training

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

8.5.1 NHS Borders

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

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

8.5.2 Scottish Borders Council

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

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

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

9. Capacity and Resilience

9.1 NHS Borders

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

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

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

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

9.2 Scottish Borders Council

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

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

10. Public Involvement, Communications and Feedback

10.1 NHS Borders

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

10.2 Scottish Borders Council:

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

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

11. Joint Health Protection Plan Action Plan

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

Table 3: Health Protection Priorities 2023-2025

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

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

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

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

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

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

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

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

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

Appendices

Appendix 2: Communicable Disease and Environmental Health in the Borders

Minority ethnic population

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

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

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

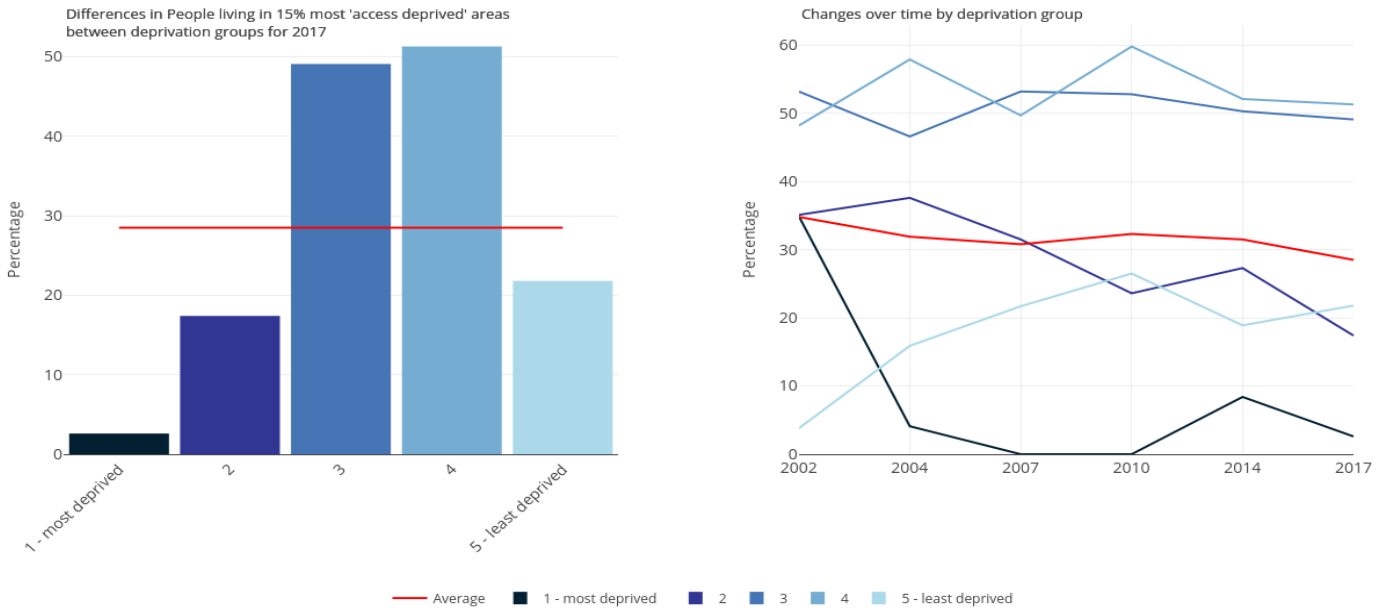

Table 4: Overview of deprivation in Scottish Borders compared to Scotland, Scot PHO Health and Wellbeing Profiles 2022

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

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

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

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

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

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

(**Table 3**).

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

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

Employment

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

Health and Deprivation

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

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

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

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

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

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

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

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

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

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

Appendix 2 - Communicable Disease and Environmental Health in the Borders

1. Notifiable Disease in the Borders

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

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

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

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

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

A CD incident may comprise of one of the following:

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

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

Table 2: Significant public health incidents or outbreaks 2023

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

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

Public Health
Screening Programmes Report
April 2020 – March 2023

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Completed by:

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Contents

Executive Summary

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

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

The screening programmes that currently take place within Scotland are:

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

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

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

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

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

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

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

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

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

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

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

Introduction

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

The screening programmes that currently take place within Scotland are:

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

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

Quality and Governance

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

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

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

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

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

Impact of Covid-19

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

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

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

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

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

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

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

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

Abdominal Aortic Aneurysm

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

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

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

Eligibility

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

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

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

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

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

Service delivery in NHS Borders

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

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

Areas of good practice

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

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

Challenges

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

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

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

Follow up and treatment

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

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

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

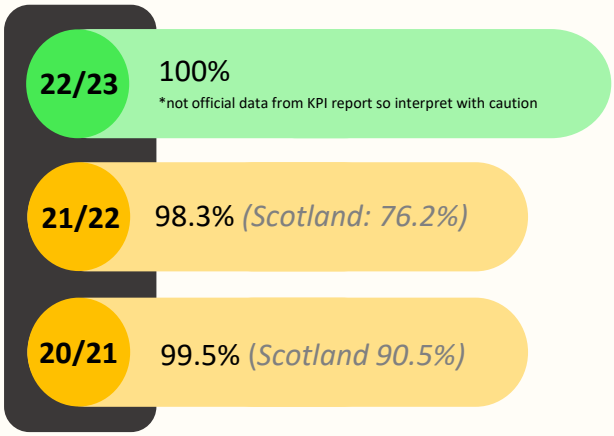
[5] NHS: Abdominal Aortic Aneurysm Screening

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

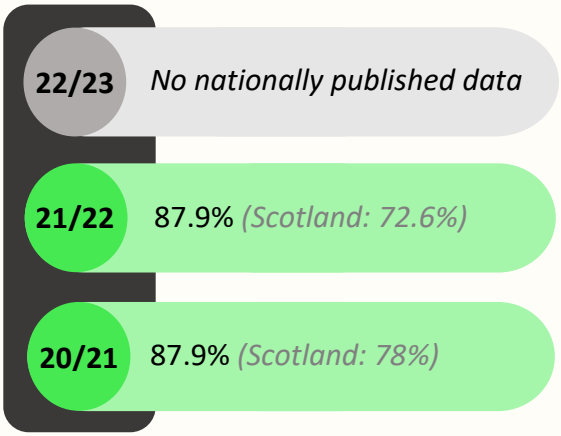
Sometimes, the aorta cannot be visualised on a scan. If this occurs, the participant will be invited for a second screen which will be at the BGH. If it is not possible to see the aorta on the second scan, local policy is to carry out a third scan using a high spec machine at the BGH, and this result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

Uptake of AAA screening in NHS Borders

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



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



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

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

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

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

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

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

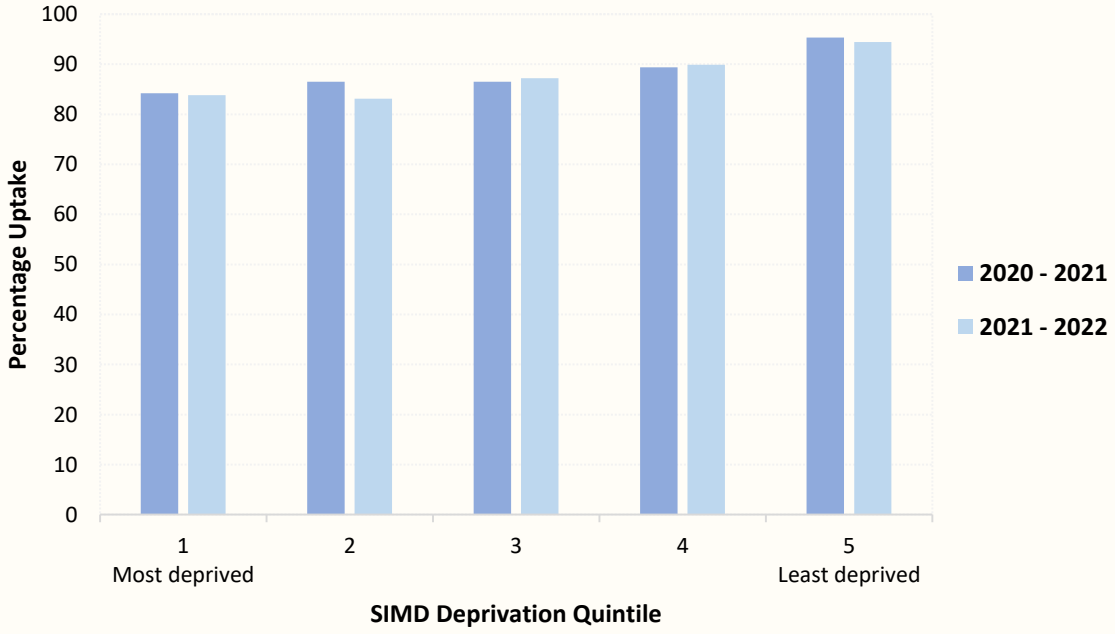
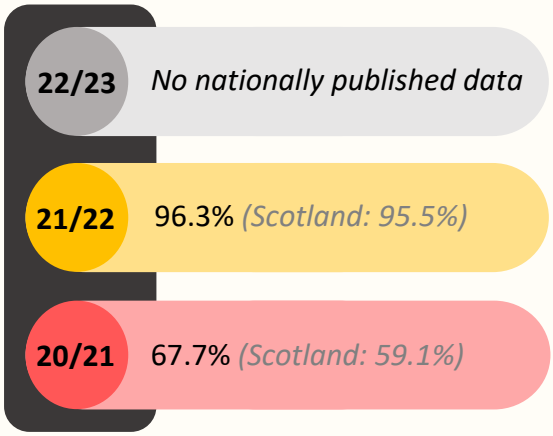


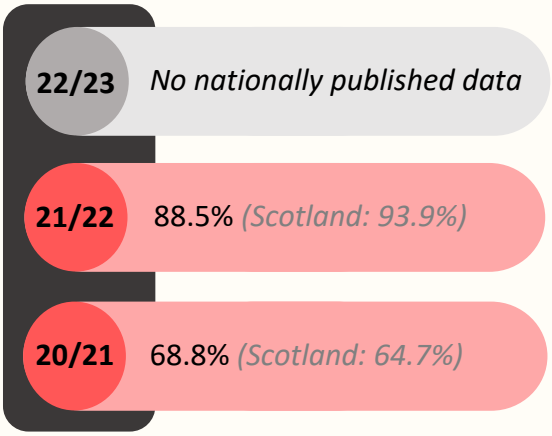
Figure 1 Percentage of men who had AAA screening within NHS Borders by age 66 years and 3 months, by deprivation quintile between March 2020 and April 2022

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

Annual surveillance



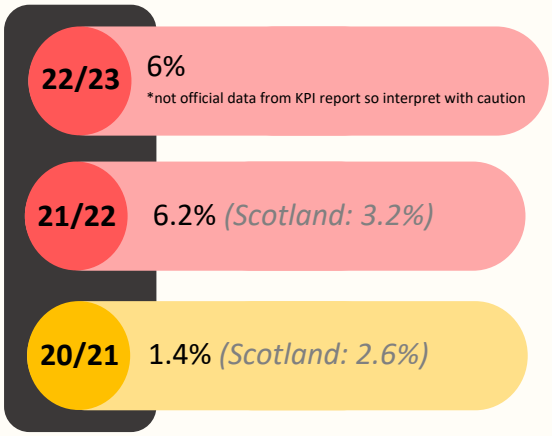
Quarterly surveillance



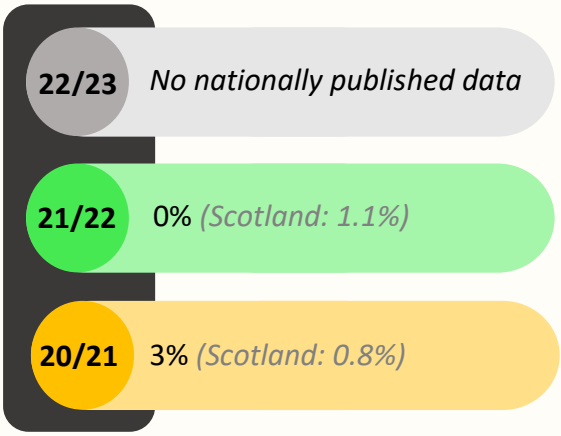
For those men who require ongoing surveillance at the Vascular department in NHS Lothian, the target is that they are screened within 6 weeks of the date of either their annual or quarterly surveillance. In 2020/21, Borders performed below the essential target for both quarterly and annual surveillance,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

Screening performance and outcomes

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



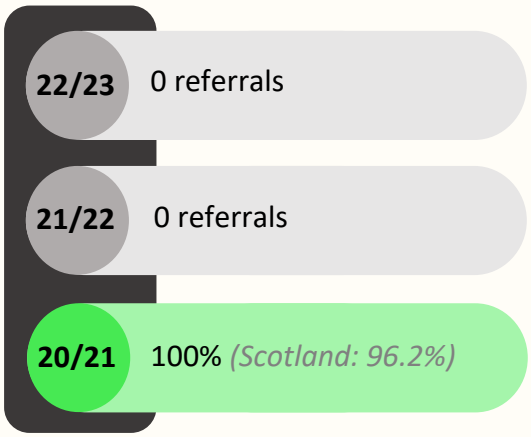
Percentage of screened images that did not meet quality assurance and required immediate recall



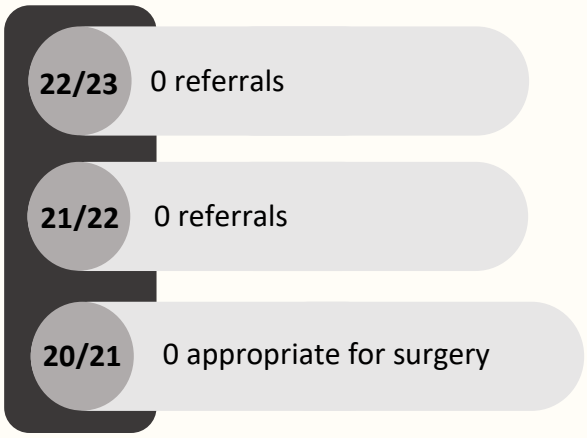
In 2020/21, there were minimal encounters where the aorta could not be visualised, and performance was better than the national average. The percentage of failed encounters

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

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



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



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

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

Identified risks

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

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

Adverse events

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

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

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

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

Bowel

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

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

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

Eligibility

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

Service delivery in NHS Borders

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

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

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

Areas of good practice

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

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

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

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

Challenges

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

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

Follow up and treatment

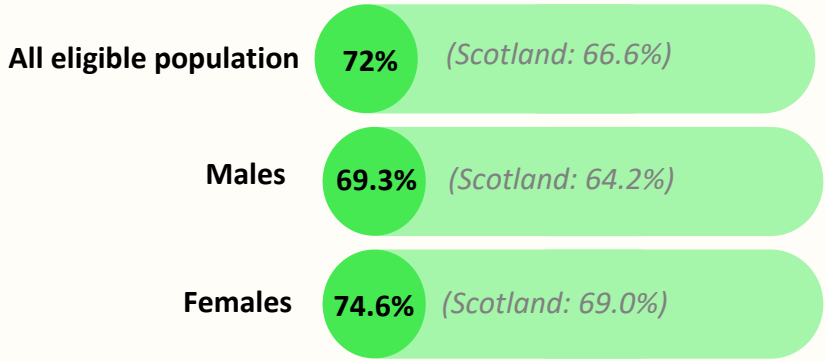
The Scottish Bowel Cancer Screening Centre aim to send individual's their results within 2 weeks.

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

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

Uptake of bowel screening in NHS Borders

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



[8] NSS: Bowel Screening

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

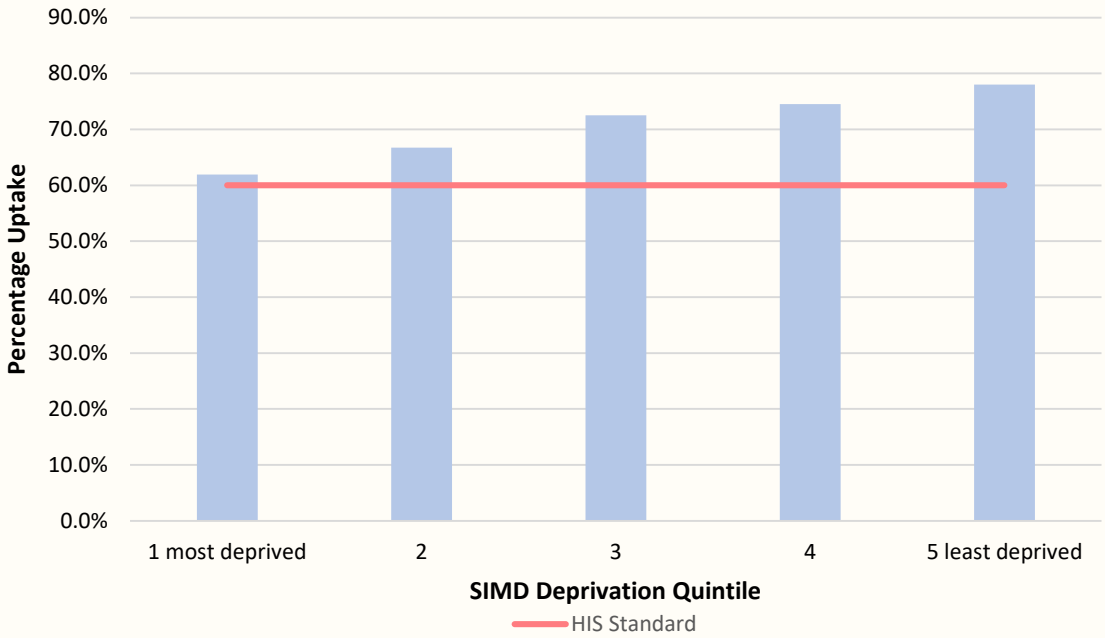


Figure 2 Uptake of bowel screening for NHS Borders between 1st Nov 2020 and 31st Oct 2022, by deprivation category

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

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

Screening performance and outcomes

Screening test positivity

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

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

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

Colonoscopy timeliness and completion

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

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

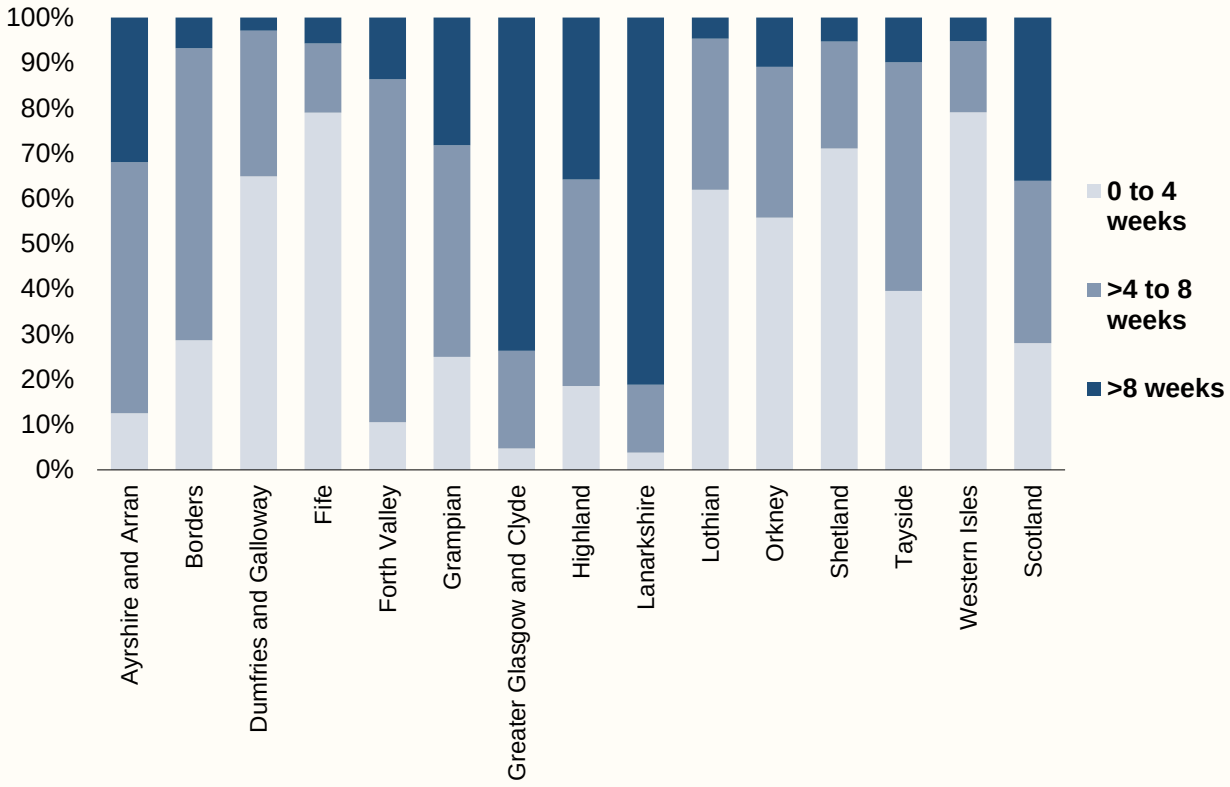


Figure 3 Time from screening test referral date to date colonoscopy performed, by NHS Board for 2020/22

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

92.8% *(Scotland: 94.1%)*

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

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

Cancer detection and staging

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

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

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

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

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

44.7% *(Scotland: 43.6%)*

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

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

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

Identified risks

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

Adverse events

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

Breast

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

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

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

Eligibility

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

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

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

Service delivery in NHS Borders

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

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

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

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

Areas of good practice

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

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

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

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

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

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

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

[11] NSS: Breast Screening

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

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

Challenges

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

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

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

Follow up and treatment

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

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

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

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

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

Uptake of breast screening in NHS Borders

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

78% *(Scotland: 73.2%)*

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

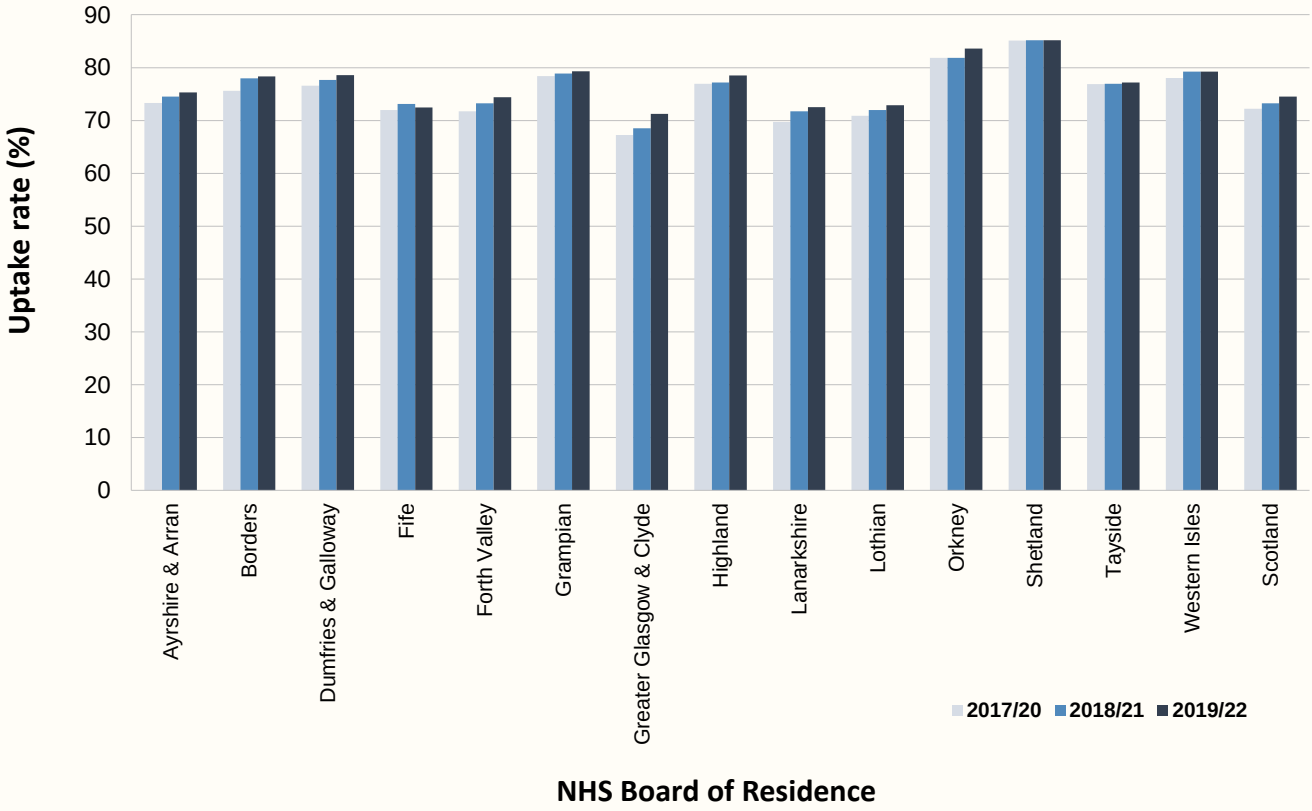


Figure 4 Three yearly uptake of breast screening across the health boards in Scotland for 2017/20, 2018,21 and 2019/22

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

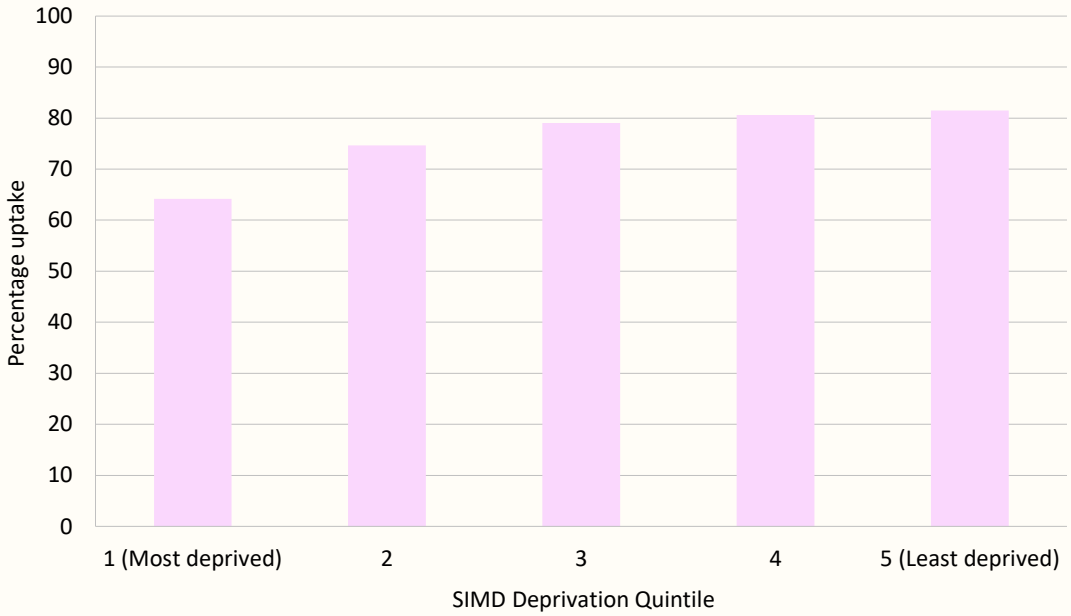
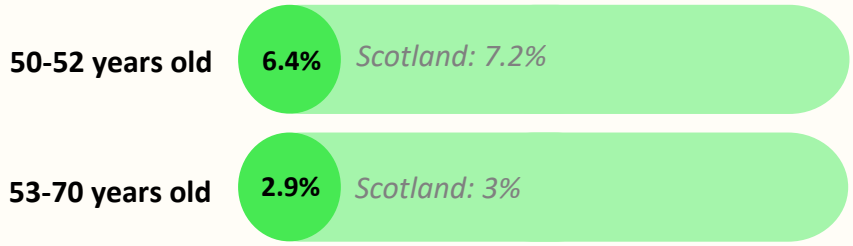


Figure 5 percentage uptake of breast screening in each deprivation category for Borders between 2019 and 2022

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

Screening performance and outcomes

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



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

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

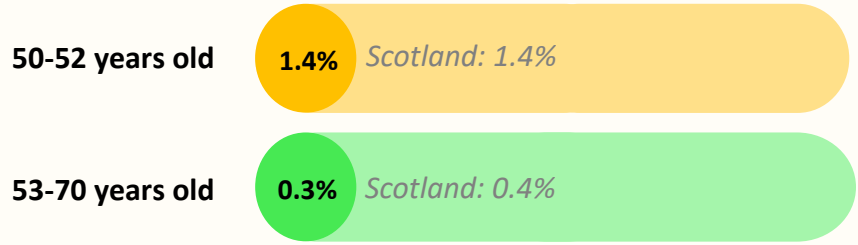
Table 5 Breast cancer detection rates through breast cancer screening for 3 year cycle from 2018/19 to 2020/21 in Borders

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

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

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

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



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

Identified risks

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

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

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

Adverse events

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

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

Cervical

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

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

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

Eligibility

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

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

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

Service delivery in NHS Borders

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

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

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

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

Areas of good practice

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

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

Challenges

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

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

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

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

Follow up and treatment

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

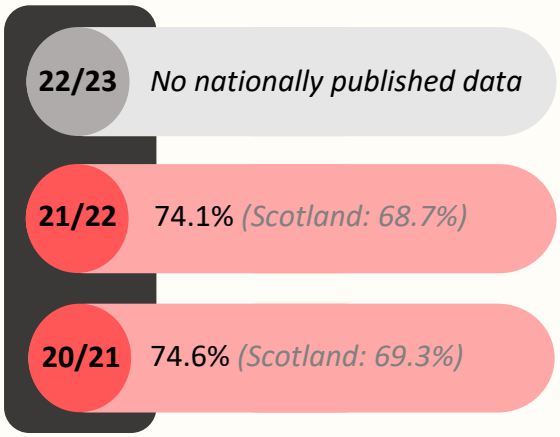
If no HPV has been found on the sample taken, then the individual will be placed back into routine screening and invited again in 5 years. If HPV was found, but there were no cell changes seen, then a further invite is issued after 12 months, in order to check if the HPV has been cleared.

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

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

Uptake of cervical screening in NHS Borders

Percentage uptake of cervical screening among NHS Borders residents



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

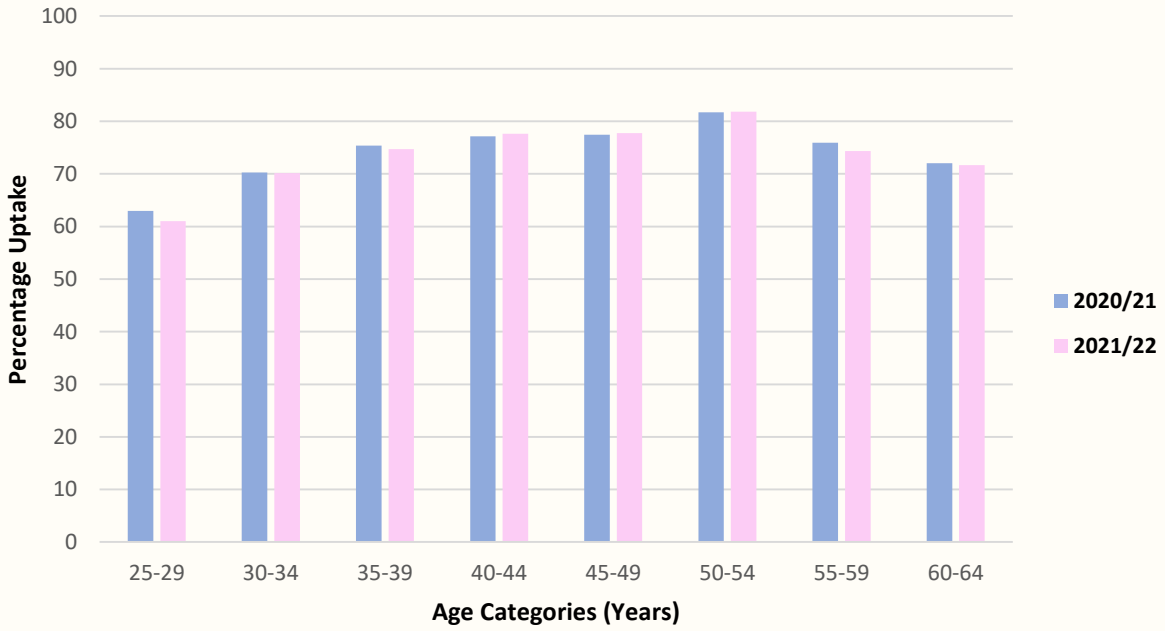


Figure 6 Percentage uptake of cervical screening within NHS Borders, by age for 2020/21 and 2021/22

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

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

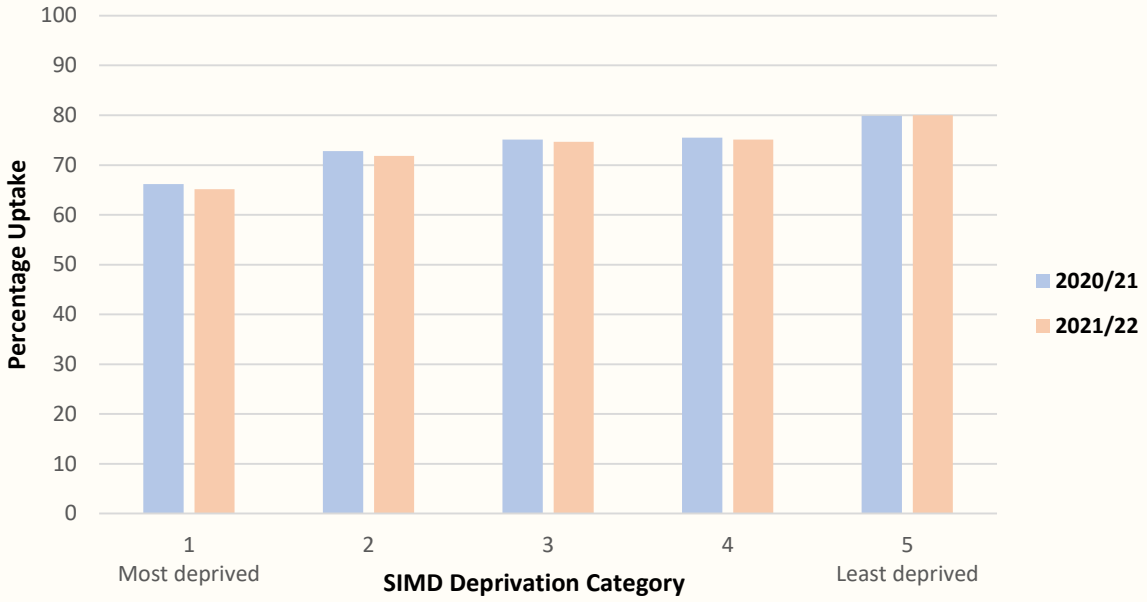


Figure 7 Percentage uptake of cervical screening within NHS Borders, by deprivation quintile for 2020/21 and 2021/22

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

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

Finally, uptake of cervical screening can be analysed by HPV vaccination status. This vaccine was introduced in 2008 and is now offered to all individuals between 11 and 13 years old in Scotland. In 2021/22, uptake in screening amongst those 25-31 years old who were fully vaccinated was 70.4% in Borders. Uptake was only 61% in those of the same age with incomplete vaccination, and was even lower (45.8%) in those with no HPV vaccine history. This may be due to immunised women being more aware of the risk of cervical cancer as a result of contact with the immunisation programme.

Screening performance and outcomes

The average turnaround time for results coming to NHS Borders varied between 15 and 17 days across Q1-Q4 in 2021/22. This was similar in 2020/21, although Q1 in this year had an average of 12 days.

There is a HIS standard that requires a minimum of 80% of individuals receive their screening results within 14 days from the date of the sample being taken. This information is not available for Borders specifically, but some information does exist for the 2 laboratories in Scotland.

In 2021/22, the turnaround time for 95% of all screening tests processed within Scotland varied between 18 and 38 days across the quarters. The range was slightly wider in 2020/21, with turnaround time varying between 14 and 43 days that year.

The number of new cases of cervical cancer diagnosed each year is very low in the Borders and fluctuates from year to year, as would be expected given the small numbers.

Identified risks

There is a risk to resilience within the call-recall function of the cervical screening programme in Borders. The team is small and so any absence has a significant impact on function.

There is a risk noted around opportunistic cervical screening samples taken within BGH wards for in-patients by staff who do not have access to SCCRS. This is alongside variation in clinical standards and correct procedures.

There is a risk that out of date vials will be used for cervical smear taking within the BGH and GP practices.

There is a risk that pregnancy exclusions are not being applied consistently in SCCRS, which means that screening opportunities could be missed.

Adverse events

There was a national incident in June 2021 regarding individuals who had a sub total hysterectomy being incorrectly excluded from the cervical screening programme. All of these people have since been identified and invited for assessment, with no cancers found. This audit was extended to include all women with an SMR code of total hysterectomy and a no cervix exclusion in SCCRS. To date in Borders, two women from over 4000 audited have been found to have been inappropriately excluded from cervical screening as they did have a cervix. This audit will be completed by March 2024.

In spring 2022, two GP practices used an out-of-date vial for cervical smear taking, and so the patients had to be invited for another smear test with the standard 3 month recovery period.

In January 2023, Monklands screening lab discarded a sample that had not yet had cytology due to an I.T. upgrade issue. Three Borders patients had to be invited back for screening due to this. In the same month, a practice nurse had taken a sample for a patient but had not printed the label at the time of the consultation. They entered another patient's notes shortly after this and created a sample label for the wrong patient. The patient had to return for a repeat sample.

Diabetic Eye Screening (DES)

The Diabetic Eye Screening programme (DES) was formally known as the Diabetic Retinopathy Screening Programme. The programme aims to check for diabetic retinopathy, which is a condition caused when high blood sugar levels can damage the small blood vessels in the retina.

People with both type 1 and type 2 diabetes are at risk of developing the condition and often there are no symptoms in the early stages of the condition. If the damage is not treated then it can lead to serious complications, including blindness. Untreated diabetic retinopathy is one of the most common causes of sight loss in working age people[14].

The screening test involves a screener taking a digital photograph of the back of the eye to detect any damage and this can take between 10 to 30 minutes. The retinal images are then downloaded for assessment and grade assignment in Optomize, the DES IT system.

Eligibility

Everyone diagnosed with diabetes, and on the SCI Diabetes database, over the age of 12 years old is invited to have DES every 2 years if they are at low risk of sight loss. Those who are at high risk of sight loss should be invited every 6-12 months for screening. Pregnant women are invited three times during/post pregnancy, due to the risk of gestational diabetes.

An individual's image grading outcome and screening history are used to determine their risk profile.

Service delivery in NHS Borders

NHS Borders commissioned NHS Lothian in 2008 to provide programme management, retinal image grading, and call-recall admin services for the Borders DES programme. NHS Borders provides the DES screeners and cameras.

The DES service currently screens at the following locations:

- Borders General Hospital
- Coldstream Health Centre
- Eyemouth Health Centre
- Hay Lodge Health Centre, Peebles
- Hawick Community Hospital
- Hawick Health Centre
- Jedburgh Health Centre
- Kelso Community Hospital
- Knoll Hospital, Duns
- Selkirk Health Centre

[14] PHS: Diabetic eye screening

The DES programme in the Borders is delivered by two (1.95 WTE) screeners, supported by Borders Screening Team, as well as NHS Lothian's Princess Alexandra Eye Pavilion programme manager, graders, and call-recall admin, who manage all screening appointments for Borders screening participants. NHS Borders Ophthalmology Department provide all OCT (Optical coherence tomography) 3D imaging for the DES programme in the Borders, as the low numbers eligible for OCT imaging following DES screening are too low to justify the procurement costs of an additional screening OCT machine.

Where a satisfactory retinal image cannot be obtained by the screeners, patients are asked to make an appointment with a local community optometrist for a slit lamp examination, who feed the results into the DES programme admin.

Areas of good practice

The Borders community optometrist model for DES slit lamp examination widens access to screening across the Borders, enabling those with poor mobility and limited access to affordable public transport to attend a relatively local optician for a screening slit lamp examination rather than having to travel to the Borders General Hospital for an Ophthalmology appointment.

Screening is delivered in a variety of community locations to make it accessible and practical. There are also monthly Saturday clinics for people who have trouble accessing clinics during the working week. Furthermore, the DES programme aims to accommodate inpatients in the BGH who have missed their screening appointment, usually on the same day that this is flagged to the team.

Patients invited to the programme are given a phone call to remind them of their appointment, and to discuss any issues with attending the appointment. This has often led to elderly patients being given an appointment much closer to home than the one they originally received from the Lothian call-recall office.

Challenges

The pool of optometrists that have been accredited by the Borders Ophthalmology Department to provide slit lamp examinations for the DES programme has declined greatly since pre-Covid. Reasons include retirement, staff turnover and financial pressures. The current screening slit lamp fee is £15 and has not been reviewed since the implementation of the DES programme in 2008. Several optometrists have either opted-out of the slit lamp programme, or intend to do so if the fee cannot be increased in line with the standard eye test which is currently £45.

Current pressures in the NHS Borders Ophthalmology department mean that although there are Optometrists willing to be accredited for Borders DES slit lamp examination, there is currently no agreement when this can be achieved. This could result in more patients being referred to Ophthalmology for a DES slit lamp examination in future.

The size and population of NHS Borders only supports the use of two screeners. This means that staff absence can have a large impact on the ability to provide screening in the board.

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

Follow up and treatment

Results are usually sent to patients within 4 weeks. Individuals' GP and diabetic specialist also receive a copy of the results.

If the result is unclear when it is being reviewed by the team, then the person will be invited back for another test.

If no retinopathy is found on the screening test, and this is the first time this has occurred, they will be invited back for screening after 12 months. From the second time onwards, the screening interval increases to 2 years.

If minor changes are found on the retinopathy screen, then the individual is usually recalled after 6-12 months for monitoring.

Finally, if more significant changes are found, then the individual is referred to a specialist eye clinic for further assessment and investigations. Approximately 1 in 25 people who have the screening test will be referred for further investigations[15].

Uptake and screening performance of DES in NHS Borders

Since the programme moved from Vector to Optomize IT system in June 2020, there have been no official published KPIs for the DES programme. This is due to many, compounding reasons.

Optomize went live during the pause in national screening programmes for Covid-19. The recall dates of those on routine recall were moved back 12 months to enable users to become familiar with the new system whilst coping with the restart of screening in a position of significantly reduced capacity. However, this made it very difficult to recall patients as no-one was technically due for screening, and the call-recall team had to manually search for patients. It emerged the DES collaborative did not order a like for like replacement I.T. system and a stream of fixes and developments were needed for equivalent functionality, particularly in the reporting capabilities. Optomize is still in its embedding phase with work on producing a reliable set of DES KPI's ongoing, and as such, no official KPIs have yet been published.

DES Screening uptake was severely affected after the programme restarted again in August 2020, post Covid-19 lockdown. There was an initial focus on high-risk patients, including pregnant and newly diagnosed, which increases by approximately 5% each year. Across Scotland the numbers being invited and screened was significantly reduced due to staffing issues, closure and slow reopening of screening venues, infection control procedures, social distancing and isolation requirements. The barriers to participating in this programme, or any of the screening programmes were huge across the country and all of these factors

[15] PHS: Diabetic Eye Screening

contributed to the low uptake and consequent DES backlogs across Scotland. Specifically, within the Borders, the service had to be centralised to the BGH at the time. This meant that a lot of people were unable or unwilling to travel long distances for a screening appointment (particularly on public transport), and there was also hesitancy around attending a hospital setting and the perceived risks involved with this, particularly for people who already had long term health problems such as diabetes and may have been shielding.

Furthermore, the above sits alongside changes made to the screening pathway in the DES programme from 1st January 2021. Revised screening intervals (RSI) were introduced, and low risk patients, who met the criteria, were given a 2 year recall. To avoid distorting the demand curve, this was phased in gradually, using a random allocation algorithm, across Scotland and not by Board. This gradual phasing in of the RSI affected the accuracy of the KPI denominator. The proportion allocated either a 1 year or 2 year screening interval varied in each Board, making the establishment of an accurate denominator difficult and a conversion formula had to be applied. Since the RSI has been implemented fully, it has now emerged that recalling patients early, to smooth the bow waves in the demand curve created by Covid-19, results in some patients reverting back to a 1 year recall interval in error.

All of these factors are complex and interlinked. They have understandably meant that no official KPI report has been published as yet. In the meantime, the call/recall office continues to monitor the performance and safety of the programme, using management performance reports. The next KPI report for this programme is due next year, and it is hoped that the 2023/24 report will provide greater clarity about the ongoing performance of this screening programme both within Borders and across Scotland.

Governance and regulation

The NHS Borders Board Screening Coordinator and Screening Services Manager attend the quarterly Lothian DES Governance meeting.

Prior to Covid-19 the NHS Borders Diabetes Managed Clinical Network (NHSB MCN) provided governance for our DES programme. The NHSB MCN has not yet resumed since Covid-19, and so resumption of a Borders DES Governance group has proved difficult. However, it is hoped that a governance meeting we be held in the next quarter to include an Ophthalmology and a Diabetic Team representative.

Internal (IQA) and External Quality Assurance (EQA) activities are undertaken by all image graders, with level 3 graders being assessed by the External Quality Assurance (EQA) system provided, and hosted by Aberdeen University. All graders must participate in at least 3 out of 4 rounds of the EQA scheme; however, its main purpose is to show that an equitable and high quality grading standard is maintained across all 9 grading centres in Scotland.

Identified risks

There is an identified risk around the capacity of Ophthalmology and Diabetes Consultants to attend governance meetings around their clinical workload.

As detailed above, service delivery resilience can be challenging with only two DES screeners in post.

A risk is noted around clinic transport for the programme, as the current DES transport is diesel. NHS Borders policy may require DES to procure an electric vehicle in the near future, and funding will be required for this.

There is a lack of capacity within the Ophthalmology department to process and perform new slit lamp accreditation requests which reduces the number that can be performed in the community, and increases demand further on the Ophthalmology department.

Adverse events

An IT system user error in August 2021 led to 29 Borders patients who were newly registered onto the DES Optimise IT System in August and September 2021 not being sent an invitation for their first Diabetic Eye Screening (DES) within 90 days by the Lothian call-recall office. Fortunately, those who went on to attend a screening appointment showed no evidence of harm, and no referrals to Ophthalmology were necessary.

Pregnancy and Newborn

Pregnancy and newborn screening involves a variety of different tests, offered to mother and baby, at stages throughout pregnancy and in the early neonatal period.

There are three primary purposes of pregnancy and newborn screening tests:

- To identify whether a woman has a condition that could harm her baby without treatment during the pregnancy or shortly after birth.
- To identify whether the baby has, or is at risk of, conditions such as neural tube defects, sickle cell disorders and thalassaemia.
- To identify if the baby's development is normal, and whether they have conditions that require treatment in utero, shortly after birth, or will limit the baby's chance of survival.

Eligibility

All pregnant mothers and newborn babies within the UK are eligible for screening at specified time points during pregnancy and after birth.

Service delivery

Pregnancy screening is integrated into routine maternity care for pregnant woman. Most screening blood tests are carried out by community midwives at antenatal appointments in local venues, but sometimes are performed by hospital midwives within the maternity department at the Borders General Hospital (BGH). Ultrasound scans for fetal anomalies are performed by sonographers at the BGH.

Newborn screening is offered to all babies born within NHS Borders. Hearing tests are carried out at the BGH, and bloodspot tests are usually performed at home by community midwives (although some may occur within the hospital setting if a baby is an inpatient at the time of the test). Movers in to the Board under the age of 12 months are offered a bloodspot test in Ward 15 Ambulatory Care if they cannot provide their health visitor with a bloodspot result.

Areas of good practice

With regards to the blood spot testing programme, Midwifery produced a local training guide, engaged in training sessions, one to one supervision and introduced new lancets in an effort to mitigate the persistent number of avoidable repeat tests within Borders.

Delays in transit time of some screening samples was greatly affected by national Royal Mail postal strikes this year. The BGH lab arranged blood bike transportation of blood spot screening samples for most of the strike dates, and within the community consideration is given to when certain antenatal clinics are booked, so that blood samples can be posted in a timely fashion (taking into account both Scottish and English bank holiday dates).

The newborn hearing screening programme in Borders is now located on the Pregnancy Assessment Unit. Two more maternity staff (band 4) have been trained which provides cover later in the day, and has reduced the need for extra clinics. There are clinics on Saturdays and

occasional Sundays, which may be beneficial for some families where a parent returns to work before the hearing screening appointment date.

Challenges

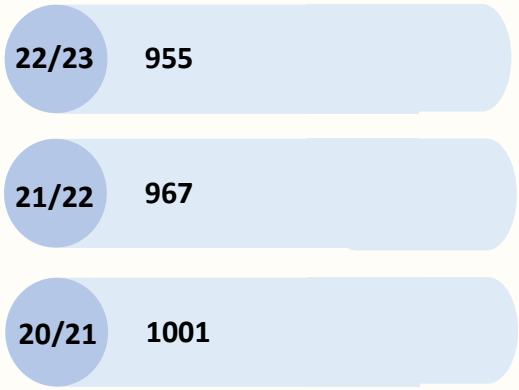
Over the past few years there have been some specific challenges within the pregnancy and newborn screening programme. Postal strikes, and the Royal Mail service in general have impacted on the timely delivery of blood tests to the appropriate laboratories.

The conflict in Ukraine saw movement of families into Borders from that area. It was difficult to locate these families at times, often resulting in extremely challenging deadlines for the test to be taken. It was also very difficult to explain the blood spot test to these families, and the reason why it was important.

Uptake, performance and clinical outcomes

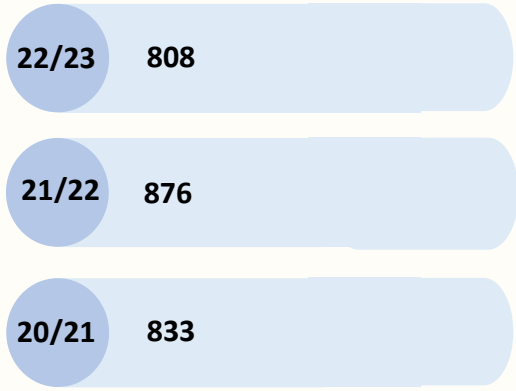
Much of the data that we have available around screening was taken from BadgerNet. The quality of the information that could be pulled from the IT system was uncertain and so the figures detailed below may not be a fully reliable representation of the KPI achievement for the last three years. This appears to be mostly due to issues around the use of BadgerNet and how to appropriately record information so that KPI figures can be pulled.

Number of booking appointments in NHS Borders



The data about booking appointments is from BadgerNet - it was not possible to know whether this figure included miscarriages, terminations, or movers into/out of the area, and so that should be kept in mind when reviewing the data.

Number of live births in NHS Borders



In 2020/21 there were 833 live births in NHS Borders. Of these, 68 babies were resident in another health board and so their ongoing care was the responsibility of that health board, leaving 765 babies for whom NHS Borders was responsible for ongoing care.

In 2021/22, there were 56 babies who were resident in another health board, leaving 820 the responsibility of NHS Borders.

In 2022/23, 64 babies were resident out of the area and so only 744 were the responsibility of NHS Borders in terms of going care.

Screening tests in pregnancy

Condition	Rationale	Test and Timing
Haemoglobinopathies	Haemoglobinopathies such as sickle cell disease and thalassaemia are inherited blood disorders that are passed on from parents to children genetically[16]. They are serious and life-long conditions, where people can experience severe pain, anaemia, and infections. Screening for these illnesses aims to allow early treatment for the baby in order to prevent damage to their liver, heart, and spleen. https://www.nhsinform.scot/healthy-living/screening/pregnancy/blood-tests-during-pregnancy	Maternal blood test and Family Origin Questionnaire (FOQ) *Sometimes a paternal blood test is also offered, as this can provide more accurate screening results* During or shortly after first midwife visit (before 10 weeks)
Hepatitis B	This virus is transmitted via contact with bodily fluids, in this context – from mother to baby during birth. The virus attacks the liver, causing inflammation and sometimes liver failure, scarring and/or cancer. Chronic disease is more likely in babies and children who are infected with the virus[17]. Screening aims to reduce the number of babies who have hepatitis B, and subsequently develop severe liver disease. https://www.nhsinform.scot/illnesses-and-conditions/stomach-liver-and-gastrointestinal-tract/hepatitis-b/	Maternal blood test Between 8-12 weeks
Syphilis	Syphilis is a bacterial illness that can be transmitted from a mother to her baby during pregnancy and/or childbirth. If a woman has syphilis during pregnancy (at any of its three clinical stages), there is a risk of the unborn baby developing congenital syphilis. Screening aims to reduce the number of miscarriages and stillbirths due to syphilis. It also aims to reduce the number of babies born with congenital syphilis as this can lead to serious life changing or life altering problems.	Maternal blood test Between 8-12 weeks
HIV	Human Immunodeficiency Virus is a virus which is transmitted through bodily fluids, in this context - from mother to baby during pregnancy, birth and breastfeeding. This virus attacks elements of the immune system, weakening it and making a person susceptible to both common and rarer infections and illness. Screening aims to reduce the number of babies born with HIV, and therefore the associated consequences of living with this illness.	Maternal blood test Between 8-12 weeks

[16] NHS: Blood tests during pregnancy
[17] NHS: Hepatitis B

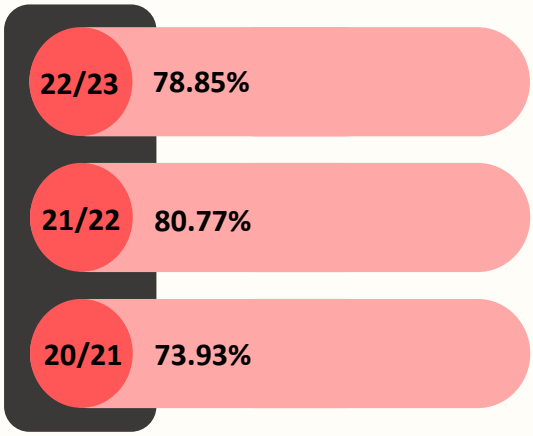
Condition	Rationale	Test and Timing
Down's Syndrome, Edward's Syndrome and Patau's Syndrome (trisomy 13, 18 or 21)	These syndromes are genetic conditions, most of which are caused by a chance mutation. In all of these syndromes, the baby has an extra copy of a particular chromosome (chromosomes are where genetic material is held in the body, and we usually have a pair of each of the 23 chromosomes). Pregnancies where the baby has a form of Edward's and Patau's syndrome have a higher risk of miscarriage and stillbirth. Those who survive can have severe medical problems, and some may have a form which is life-limiting. Down's syndrome is not considered to be a life-limiting condition, but children born with this can have a higher risk of certain medical conditions. Screening for these syndromes allows families to make informed and supported decisions about the risk of their baby having the conditions, and offers the choice of going on to have an invasive diagnostic test.	Maternal blood test and ultrasound scan *Can choose to screen for all, some, or none of the conditions* Between 11-14 weeks *If the woman is between 14-20 weeks, then they can only be screened for trisomy 21, and only with the blood test*
Fetal anomaly	This test is a detailed ultrasound scan, usually performed by a sonographer. The fetal anomaly ultrasound scan identifies serious fetal anomalies which are incompatible with life or associated with morbidity. It also identifies anomalies which may benefit from intervention during the pregnancy, or soon after the birth of the baby. The scan can be dependent on the position of the baby, maternal weight, fluid around the baby and scarring in the abdomen from previous procedures. It also is unable to identify anything that might develop later on in pregnancy, or any problems that aren't structural in nature.	Ultrasound scan Between 18-21 weeks

Condition	Rationale	Test and Timing
	Conditions that can be identified at the fetal anomaly screening include: • Anencephaly • Open spina bifida • Cleft lip • Diaphragmatic hernia • Gastroschisis • Exomphalos • Serious cardiac anomalies • Bilateral renal agenesis • Lethal skeletal dysplasia • Edwards syndrome • Patau's syndrome Detecting any developmental issues during pregnancy allows for early support to be offered to parents in order for them to make informed decisions. It also enables interventions to be carried out in utero if required, and for plans to be made around birth and early life with the aim of improving outcomes.	

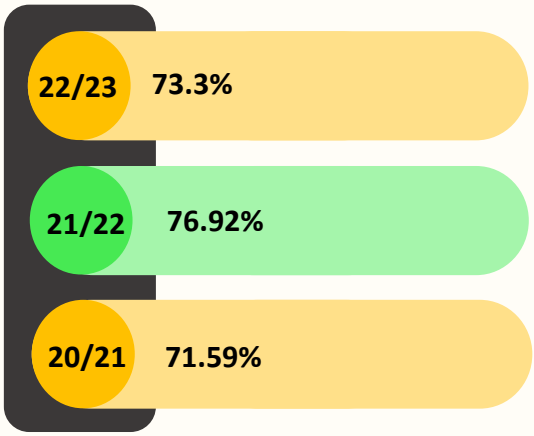
Haemoglobinopathies

The percentage of women offered haemoglobinopathy testing increased slightly in 2021/22 (90.61% to 92.86%) but then declined again in 2022/23 (91.83%). It is unclear whether the pregnancies that were recorded as not being offered testing were genuinely not offered or whether this was not recorded correctly on the BadgerNet.

Percentage of pregnancies in NHS Borders where a haemoglobinopathy screening result was available



Percentage of pregnancies in NHS Borders where the screening result was available by 10 weeks + 0 days



The percentage of pregnancies where a screening test result for haemoglobinopathies was available also increased in 2021/22 but declined slightly again in 2022/23, though not to as low as 2020/21. In none of these years however was the essential national target met.

Women should receive a haemoglobinopathy screening result by 10 weeks + 0 days' gestation. In 2020/21 and 2022/23, the essential national target for this was met. In 2021/22 there was again an apparent increase compared to the other two years, and the desirable national criteria was met in this time period.

	Total number on whom an antenatal screening sample was performed	Number of women with an abnormal haemoglobinopathy screen at any gestation
April 2022 – March 2023	869	342
April 2021 – March 2022	884	254
April 2020 – March 2021	894	200

Table 6 The number of women who had a haemoglobinopathy screening result, and the number of abnormal results in NHS Borders for April 2020 - March 2021, April 2021 - March 2022 and April 2022 - March 2023 (BadgerNet)

The number of women with an abnormal result at screening has been increasing over the last three years, and understandably, so too have the number of babies born to mothers with an abnormal result.

We have not been able to obtain information regarding the completion of the Family Origin Questionnaire due to resourcing issues within our local laboratory.

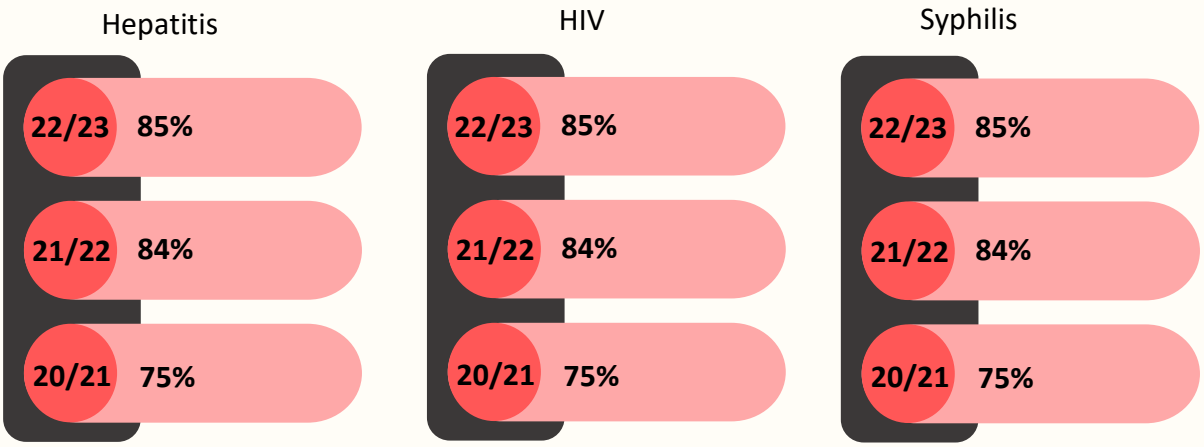
We were also unable to obtain numerator data for the final KPIs in this section (timely offer of prenatal diagnosis, timely reporting of newborn positive screen, and timely receipt into specialist care) as the information was not available to pull within the local IT system.

Infectious Disease Screening

There are three tests offered for infectious diseases in the first trimester; hepatitis B, syphilis and human-immunodeficiency virus (HIV).

The percentage of women offered hepatitis B, syphilis and HIV testing in NHS Borders has remained fairly similar over the past 3 years, with a slight increase in 2021/22 (91% to 93%), and then decline again in 2022/23 (92%).

Percentage of pregnancies in NHS Borders where a screening result was available



The percentage of women who have had a hepatitis B, syphilis and HIV screening result available in NHS Borders has been the same each year for the past three years. It is not surprising that these are the same, given that the tests are offered and conducted at the same time if consent is given.

For each of these three tests, the percentage of pregnancies with a result available has been increasing. This is potentially due to a decline in the number of women who had a test performed but no result available (decreased from 143 in 2020/21 to only 58 in 2022/23). The numbers of women who were recorded as not having been offered these tests has varied over the last years (92 in 2020/21, 67 in 2021/22 and 77 in 2022/23).

We were unable to access data regarding test turnaround times due to resourcing within our local laboratory.

We were also unable to obtain numerator data for certain KPIs for hepatitis B (treat/intervene, timely assessment of women with hepatitis B, and timely neonatal vaccination and immunoglobulin) as the information was not available to pull within the local IT system.

There have been no cases of maternal syphilis or HIV recorded over the last three years on the IT system or within our sexual health service, and so the last KPI for syphilis (3.3 – treat/intervene) as well as HIV (4.3 – treat/intervene) is not applicable.

Down's Syndrome, Edward's Syndrome and Patau's Syndrome

There are no national targets for the coverage of trisomy 13, 18 or 21 screening in Scotland. In Borders, the percentage of eligible women for whom a completed trisomy 13, 18 or 21 screening result was available from the first trimester has varied across the years from 2020 to 2023; 58% in 2020-2021, rising to 68% in 2021-2022 and dropping a little again to 65% in 2022-2023.

	% of screens in Second trimester
April 2022 – March 2023	9.3%
April 2021 – March 2022	8.7%
April 2020 – March 2021	13.7%

Table 7 Percentage of second trimester screens (trisomy 13, 18 and 21) for NHS Borders between 1st April 2020 and 31st March 2023 (Down's syndrome screening laboratory)

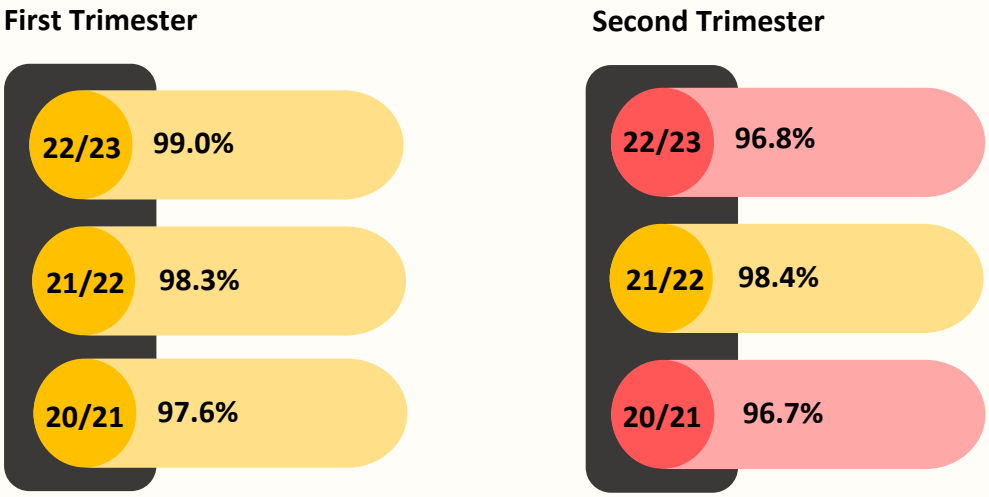
Ideally screening should take place in the first trimester, but a small percentage of women are screened in the second trimester. The percentage in NHS Borders has been improving over the past 3 years and is consistently below the Scottish figures, which is the preferred situation.

	Percentage who declined Down's syndrome screening	Percentage who declined Edward's and Patau's syndrome screening
April 2020 – March 2021	14%	15%
April 2021 – March 2022	12%	11%
April 2022 – March 2023	17%	7%

Table 8 Number and percentage of women who declined screening for Down's syndrome, and Edward's/ Patau's syndrome between April 2020 and March 2021 (BadgerNet)

The figures in the table above show the percentage of women who have declined screening for both Down's syndrome and Edward's/Patau's syndrome, which were taken from BadgerNet. It is unclear how well this is documented within the IT system, and reliability is slightly called into question by the differences in decline rates between the syndromes (given that the screening for these syndromes is offered at the same time).

Percentage of completed request forms for trisomy in NHS Borders



A request form for trisomy screening is considered incomplete if it is missing any of the following information: sufficient information for the woman to be uniquely identified, woman's correct date of birth, maternal weight, family origin, smoking status, ultrasound

Within NHS Borders, there has been an improvement in the percentage of complete request forms for first trimester trisomy screening over the past 3 years, with all year's meeting the essential national target for this. There had been an improvement in the second trimester request forms between 2020/21 and 2021/22, but this has declined again in 2022/23. NHS Borders only met the essential national target in 2021/22 for second trimester screening.

All samples sent by NHS Borders were within the correct gestation – none were sent at gestations that were considered too early or too late.

	Number of samples arriving too late for analysis
April 2022 – March 2023	5
April 2021 – March 2022	4
April 2020 – March 2021	4

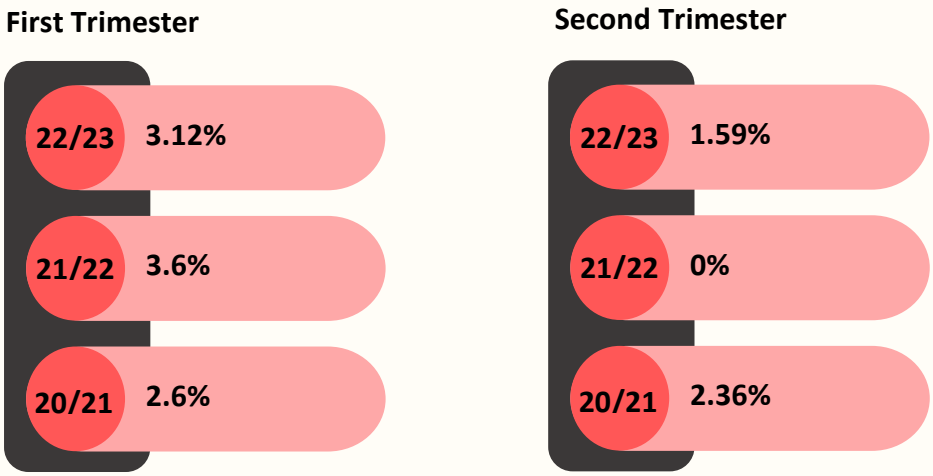
Table 9 Number of samples arriving late to the lab from NHS Borders in 2020/21, 2021/22 and 2022/23

There is a consistent pattern of some samples arriving at the laboratory too late for analysis (samples have 72 hours to arrive at the laboratory, after which due to sample degradation they are unable to be analysed and a further sample is required for analysis).

Issues within the postal service are felt to be the major factor in samples not being transferred to the laboratory within the appropriate timeframe. Official postal strikes from May 2022 had

a notable significant impact on the delivery of samples, but there have been ongoing problems with the standard of the postal service out with this timeframe.

Screen Positive Rate for Trisomy 21 in NHS Borders



The screen positive rate for trisomy 21 screening in the first trimester in NHS Borders declined a little between 2021/22 and 2022/23, but the rate across all three of the previous years has not met the essential national target.

For second trimester screening, the total percentage of women with an increased chance of any of these syndromes rose between 2021/22 and 2022/23, but Borders was again out with the national essential range. These lower results may be associated with a lower than expected detection rate.

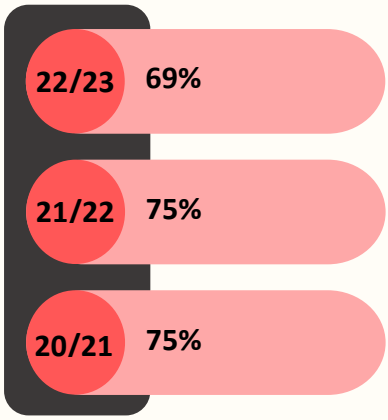
It is important to note due to the size of NHS Borders, the numbers actually screening positive for these syndromes are very small. The percentages should therefore be interpreted with caution.

It was not possible to obtain details about the time to intervention within Borders – that data could not be pulled from the IT system.

From the information recorded on BadgerNet it appears that every woman who was given a higher chance result over the past three years chose to not have any further testing. This means that no pre-natal diagnosis for Down's syndrome was performed, and so KPI 5.7 is not applicable.

Fetal Anomaly Scan

Percentage of women being scanned between 18+0 and 22+6 weeks in NHS Borders



The percentage of women being scanned within the target range of 18+0 weeks and 22+6 weeks has declined between 2021/22 and 2022/23. The number with no scan data recorded in BadgerNet has increased over the last 3 years (162 in 2020/21, 191 in 2021/22 and 245 in 2022/23), so this may be a potential explanation for the apparent drop in percentage of women scanned within the target timeframe.

The number of women having a fetal anomaly scan, but outside of the target window declined from 84 in 2020/21 to 48 in 2021/22. This remained stable at 49 in 2022/23.

There were very low numbers of pregnancies with a fetal anomaly detected over the past 3 years, although they have been increasing slightly (3 in 2020/21, 8 in 2021/22 and 11 in 2022/23).

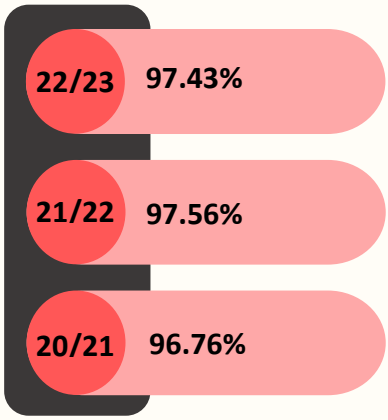
Although we were able to find out the number of scans that had an anomaly detected, we were unable to obtain data specifically regarding serious cardiac anomaly (and how many went on to have this confirmed). We were also unable to obtain data for time to intervention post-scan, as well as diagnosis as this requires referral to a tertiary centre (which for NHS Borders means a referral out of Board).

Screening tests in newborn period

Condition	Rationale	Test and Timing
Hearing	There can be many reasons for hearing loss in neonates and early childhood, from genetic causes to infections. It can be difficult for parents and carers to identify reduced hearing in this age group, and so a formal hearing test is offered in the first few weeks of life, in order to identify those with a likelihood of hearing loss. The aim of this test is to detect any problems with hearing as early as possible. This means that support and information can be offered to families (who often have not experienced hearing loss before) in order for babies to have a better chance of developing language, speech and communication skills.	Earpiece in baby's ear, or sensors on their head/neck with an earpiece or headphone in or over their ear First few weeks of life
Blood spot test	The blood test aims to detect nine serious inherited conditions that are not identifiable from physical examination alone. These diseases are associated with various issues such as developmental problems, learning difficulties, growth restriction, anaemia, pain, breathing problems, digestive issues, life-threatening illness and even death. Detecting these conditions early enables early treatment which can improve health, and prevent severe disability and/or death. The blood spot test screens for: • sickle cell disease • cystic fibrosis (CF) • congenital hypothyroidism (CHT) • phenylketonuria (PKU) • medium-chain acyl-CoA dehydrogenase deficiency (MCADD) • maple syrup urine disease • isovalericacidaemia (IVA) • glutaricaciduria type 1 (GA1) • homocystinuria (HCU)	Blood test from a baby's heel 5 days after birth

Hearing

Percentage of babies' resident in NHS Borders being screened within 4 weeks of birth

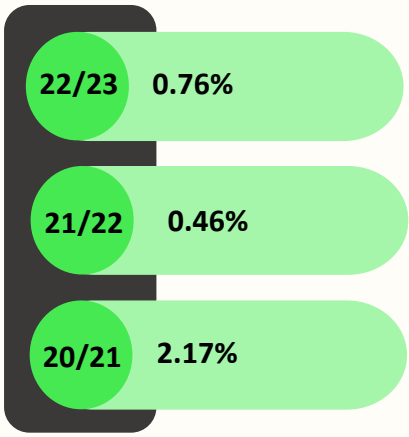


Within NHS Borders, the percentage of babies having screening within 4 weeks of birth has been consistently around 97% for the past 3 years.

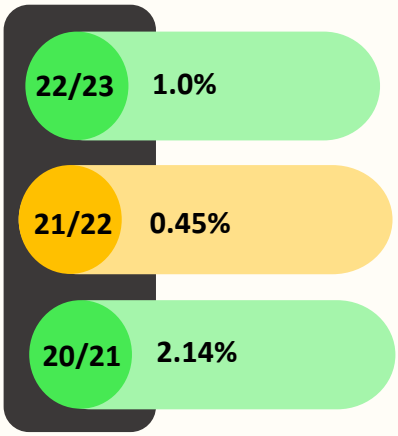
The lowest was in 2020/21, and this appears to be due to more babies missing their appointment (8 babies missed an appointment during that time frame, compared to 3 in 2021/22 and 1 in 2022/23). This is potentially related to Covid-19, as April 2020 - March 2021 was at the peak of the pandemic.

A large number of the remaining babies are either out of coverage area (8 in 2020/21, 7 in 2021/22 and 8 in 2022/23), or had their test after 4 weeks (8 in 2020/21, 10 in 2021/22 and 8 in 2022/23). Other less common reasons for not being screened include death, parental decline and the test being contraindicated.

Percentage of babies' resident in NHS Borders who do not show a clear response in both ears at AABR1



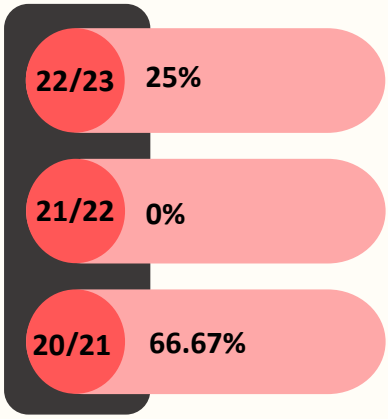
Percentage of babies' resident in NHS Borders who required an immediate onward referral to audiology



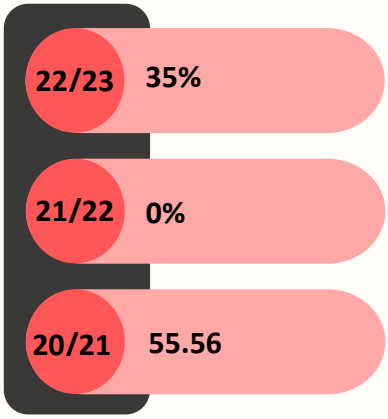
The proportion of well babies who did not show a clear response in both ears at the first test (AABR is the test type used in Borders) has been within the desirable range for all three years. The percentage of babies screened who required an immediate onwards referral to audiology has also been within essential limits for the past three years, and within the desirable range for the last two years.

Percentage of babies' resident in NHS Borders requiring audiology referral who:

Received an appointment within 4 weeks of screen or by 44 weeks gestational age



Attended an appointment within 4 weeks of screen or by 44 weeks gestational age



Only 2/3rds of the babies who required an onward referral in 2020/21 received an appointment within 4 weeks - the remaining babies were offered an appointment but it was out with the 4 week window. During the same year, just over half of babies requiring audiology review babies attended an appointment within 4 weeks. Of the remaining babies, only 2 didn't attend at all, the rest were seen but out with the 4 week window.

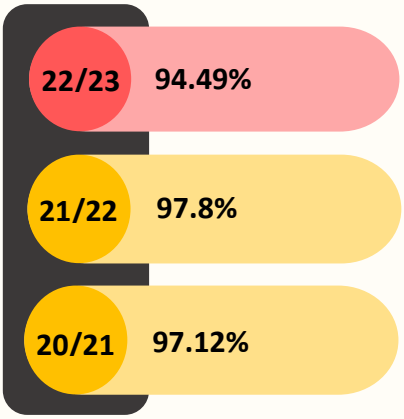
In 2021/22 a very small number of babies were referred (4). None of these babies were offered an appointment within 4 weeks and so none were seen within 4 weeks. 3 of the babies did attend an appointment at a later date, and the outcome of the 4th baby is not known.

In 2022/23, 25% of babies were offered an appointment within 4 weeks. The remaining babies were all offered an appointment but out with the 4 week window. In the same year, 25% of babies attended an appointment within 4 weeks, with the rest being seen but at a later date.

There is the potential that some of these delays were due to recovery in waiting times within the audiology service after the peaks of Covid-19. The numbers are very small with regards to these performance indicators however and so it is difficult to infer any meaningful patterns or trends.

Blood spot test

Percentage of babies' resident in NHS Borders with a bloodspot test result by 18 days of age

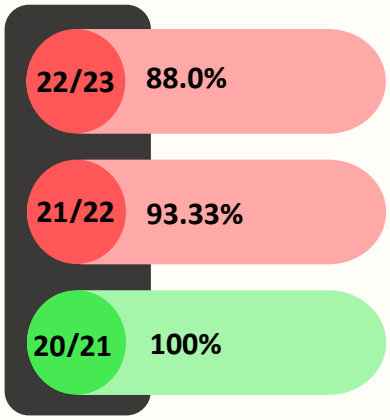


In 2020/21, most babies for whom NHS Borders was responsible had a blood spot test result recorded (99.7%), however, only 97.12% had a blood spot result recorded by 18 days of age. The reason for some blood spot tests being recorded after 18 days of age is likely due to the high number of avoidable repeat tests that were noted in that same year.

In 2021/22, 99.8% of babies for whom the board was responsible had a blood spot test recorded, but only 97.8% of these was within the 18 day time frame. Similarly, in 2022/23, 99.7% of eligible babies had a blood spot test recorded, but there was a decline in the percentage completed by 18 days of age – this dropped to 94.49% which was out with the essential national target level.

A partial explanation for this decline in performance may be that 33 of the 39 babies whose blood spot test was recorded after 18 days of life were born in November and December 2022. This was when there were postal strikes, and may explain the delay in the results being obtained. Furthermore, during this year, as a result of the conflict within Ukraine, there were babies who moved into NHS Borders from that region. It was difficult to initially locate some of these older babies and their parents, and also challenging to communicate with them vital details such as where they had to take their baby for the blood spot test. In one instance a community nurse was required to attend a hotel to explain the importance of the test and to take the blood spot test from a particular family.

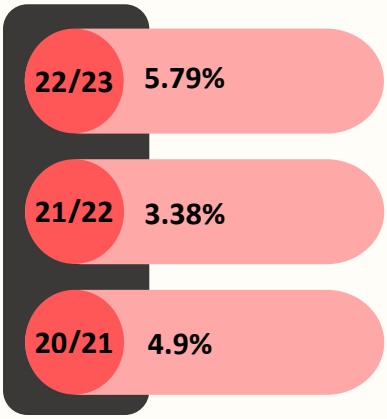
Percentage of movers-into NHS Borders who had blood spot recorded within 21 days of notifying the move



It is important that systems are in place to identify babies without a blood spot test in a timely fashion. In the Child Health Records Department (CHRD) in NHS Borders, a report is run on SIRS which can then be downloaded the next day, so that overdue reports can be chased up. This is performed twice a week (run on a Friday, downloaded on a Monday, and run on a Wednesday, downloaded on a Thursday).

One of the reasons that children may not have a blood spot test recorded is movement into the country, or from one health board to another. For this reason, CHRD keep track of babies who move into NHS Borders and their blood spot status. Performance on this measure in 2020/21 was 100% for Borders and within desirable national levels. Performance has declined over the last 2 years and fallen outside of the essential national criteria.
The reasons why a result was not recorded within 21 days are mostly due to the baby having a blood spot test but outside of the required window.

Percentage of samples requiring an avoidable repeat in NHS Borders



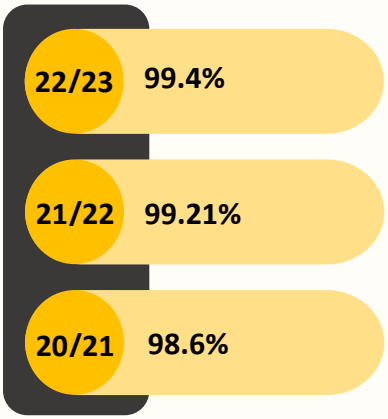
Samples which have an avoidable failure cause unnecessary pressure on the system, delays, work for staff (including laboratories), and distress for families. In all three of the previous years, Borders has been outside of the essential national target for these.

The most common reasons are due to an insufficient sample being sent to the laboratory or a missing/incorrect CHI number. Other reasons include incorrect application, sample being

from a baby who was < 4 days old, sample was compressed/not dried, samples being too long in transit, and finally the use of an expired card.

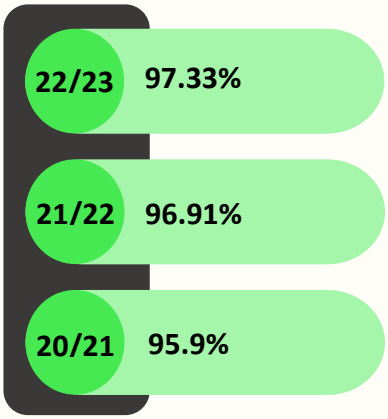
Levels in 2022/23 were the highest of the three years. Most of the increase was due to insufficient samples being sent – these were double that of the previous year. More samples were also delayed in transit compared to previous years.

Percentage of samples with a missing CHI number in NHS Borders



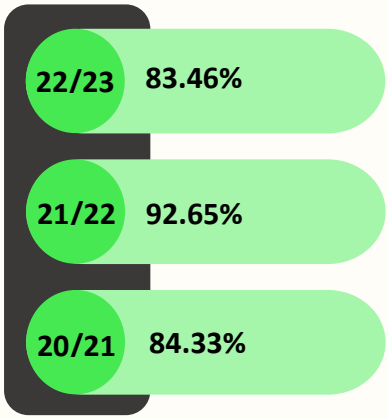
The number of samples with a valid CHI number has been slightly increasing over the last three years due to staff having a colleague double check the form where practicable.

Percentage of first blood spot samples taken between 96-120 hours of life in NHS borders



Across the previous 3 years, the majority of blood spot samples are being taken within the correct age range in NHS Borders, meeting the national desirable criteria. The percentage has also been improving across this time frame.

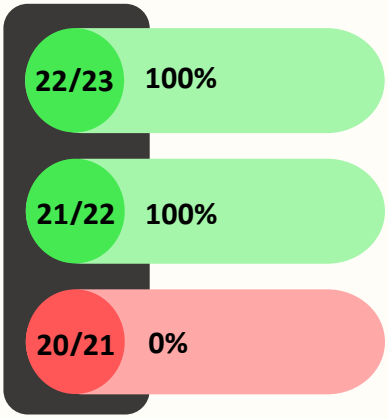
Percentage of blood spot samples received less than or equal to 3 working days of sample collection in NHS Borders



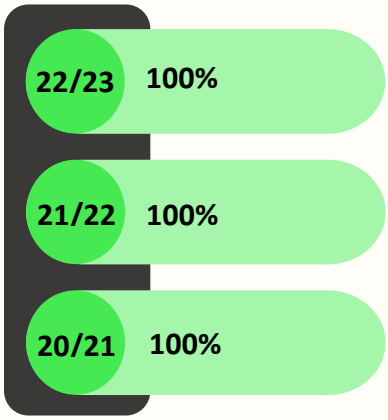
In 2022/23 there was an increase in the numbers of blood samples that were delayed in transit. Covid-19 is likely to have played a significant role in the 2020/21 low figures, but it is difficult to know the exact cause behind the decline again in 2022/23. It is possible that the postal strikes were a factor in the delay between collection and receipt in the laboratory. The team are careful about when clinics are scheduled, and consider both Scottish and English bank holidays when arranging blood tests, due to the fact that they need to be posted to the relevant labs.

Percentage of second blood spot samples taken in NHS Borders for:

Raised IRT (cystic fibrosis test) between 21 - 24 days of life

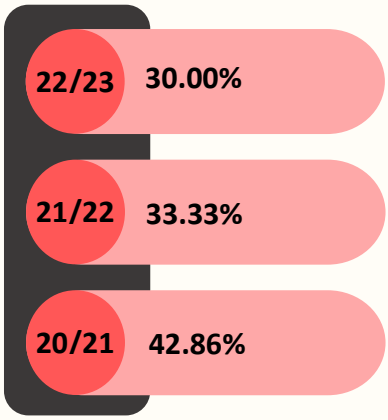


Borderline TSH between 7 - 10 days of life



With regards to second blood spot samples, and the age range at which they are taken, it is very difficult to interpret or extract any meaningful trends because the numbers in question are incredibly small. It can be highlighted that in 2021/22 and 2022/23, any repeat blood spot tests that were required for cystic fibrosis or congenital hypothyroidism were taken in the correct age windows.

Percentage of second bloodspot samples taken on or before day 28 for preterm infants (or on day of discharge if it comes before this)



Additionally, second blood spot samples for preterm infants should be taken on or before day 28 (or on day of discharge if it comes before this). Across all three years, NHS Borders is performing less well for this, and the percentage has been worsening over the three years. The blood samples appear to be taken later than required. Again, however, the numbers being analysed are very small, and so it is difficult to come to reliable conclusions regarding these.

Across all three of the years, for Scotland, 100% of all screen positive infant metabolic diseases (excluding homocystinuria), and screen positive congenital hypothyroidism were referred onwards within 3 working days.

The data is not available for NHS Borders specifically, but it would follow that the board was also at 100% for this performance metric.

Within NHS Borders between April 2020 and March 2023 there has only been one positive result from the blood spot tests. This baby was referred onwards and seen by 9 days of age.

Identified risks

There are certain risks that have been identified and are under continual review within the pregnancy and newborn screening programme in NHS Borders. This information has been taken from the local risk register.

- Within the sonography department there is a risk of lack of staffing causing interruption to the fetal anomaly scanning programme. The sonography workforce is proactively managed, along with their workload to mitigate this risk. There are further risks that a screening result might be inaccurately interpreted or documentation incomplete. This is kept under review, helped by the small team who work closely together, sharing best practice.
- There is a risk that women may miss the opportunity to have screening. This risk is mitigated by keeping staff training up to date, and having clear protocols and guidance for the screening programme.
- There is a risk that samples may be delayed in getting to the relevant laboratories. Clinics are planned around Scottish and English bank holidays, courier and transport

needs are regularly reviewed, and NSD are currently reviewing their logistical role in coordinating courier transport.

- There are challenges around collecting robust local data to monitor the pregnancy and newborn screening programme. Plans are in place to look at the data collection and reporting process going forward, with a public health practitioner currently working on a data quality project in this area, and creating a BAU process for maternity.
- There is a risk that screening results may not be acted upon. This ties into the work above around monitoring the data, and auditing whether or not any positive results have been actioned.
- There is a risk that a baby may miss the opportunity for blood spot testing. There are robust checks within the child health records department to monitor blood spot testing, and follow up any babies who do not have a blood spot test recorded until a result is obtained.
- There was a risk identified due to the lack in UNHS screening manager cover, but an interim manager has since been appointment to the role.
- There is a risk that during the transition to a new CHI system, a period of downtime could impact on the blood spot screening programme and cause babies to be missed. This was discussed nationally and reassurance was given that the downtime would be minimal.
- There is a risk that that the Board Screening Co-ordinator is not notified of an incident or adverse event, particularly when staff change job role. It was decided that maternity services and child health staff need to inform the Board Screening Co-ordinator, the Screening Services Manager and the Director of Public Health of any impending, actual or near miss screening incidents or adverse events within our Board immediately upon discovery.
- There was a final risk noted about patients receiving outdated information if the leaflets on BadgerNet were not kept up to date. It was noted that the leaflets on BadgerNet are automatically updated by Clevermed.

Adverse events

There has been one adverse event in 2022/2023. NHS Borders identified that there were three babies referred for onwards audiology assessment who had a delay in receiving an appointment for diagnostic investigation in Lothian due to a misunderstanding around the correct protocol. A PAG was held to investigate the concerns and develop actions to prevent any further occurrences of this issue. As a result of this, a new screening SOP for protocol, communication and escalation within the hearing screening programme was to be implemented. In addition, there was an action to strengthen the communication across the programme with stakeholders including robust clear communication pathways between NHS Borders and NHS Lothian regarding any policy procedural changes.

Equality

Across all of the screening programmes it is a policy to make them as accessible as possible. Screening is provided as close to home as is feasible within the resources available. For example, the breast and DES programmes use mobile units which visit different areas of the Borders, the cervical programme is carried out through primary care, and the AAA programme uses some community venues to provide options across Borders. In many programmes, appointments are also available in evenings or weekends, in order to improve accessibility.

In addition to this, Borders is in the process of developing an action plan to respond to the PHS Equity in Screening Strategy which will focus directly on the equity of programmes in the Board, as well as a Health Inequalities Strategy which has scope over all of health, healthcare and outcomes, including screening.

Furthermore, there are some specific initiatives that have been taking place within Borders to improve accessibility and screening uptake for all of the population. These include the Confident Conversations initiative with the Wellbeing Service and Health Improvement Team, staff training sessions, and outreach education in the community. There is also work being carried out with the learning disability community to enhance communication and reporting around screening (Bridging the Gap initiative, and ensuring that specific screening programme attendances are explicit questions within the new Learning Disability annual assessment questionnaire).

This year's cancer screening inequalities grant is funding a project which will focus on the impact pregnancy has on cervical screening uptake and defaulting in NHS Borders. Work is beginning in August 2023, and recommendations will be made which will involve midwives, health visitors, GP admin and call-recall to reduce the number of pregnant women who default from cervical screening during pregnancy and do not attend for screening after delivery. This group are at high risk of not being invited again until 5 years after their last invitation.

Conclusion

Looking across all of the screening programmes, NHS Borders tends to perform quite well in comparison to Scotland and other health boards.

In particular, uptake of screening in the AAA, bowel, breast and cervical programmes in Borders was consistently higher than the Scottish average over the last three years. Furthermore, the AAA (April 2020 – March 2023), bowel (Nov 2020 - Oct 2022) and breast (April 2018 - March 2021) programmes in the health board did meet the required essential national targets laid out in the HIS standards and KPIs with regards to screening uptake during their respective time frames.

On the other hand, there are areas were performance was below required national HIS standards and national KPIs.

The percentage of those taking part in cervical screening in NHS Borders following an invitation in both 2020/21 (74.60%), and 2021/22 (74.1%) did not meet the national standard of 80%. In addition, there is a wide variation in uptake within this programme across age categories (61% in 25-29 age group, compared to 71.6% in 60-64 age group in 2021/22).

Furthermore, it is worth noting the stark differences in uptake that are seen across deprivation categories in many of the programmes. The latest data shows that the gap in uptake of screening between the most and the least deprived areas of Borders was 10.6% for AAA, 17.3% for breast, 16.1% for bowel and 14.9% for cervical screening. In most cases, uptake in the most deprived category does not meet the national standards in Borders, whereas it is comfortably attaining them within the least deprived groups. Although not measured within national standards or KPIs, nor readily available in national data, it is known that there are many other inequalities that are also experienced within the screening programmes. These include differences in uptake due to accessibility (particularly felt in rural areas like the Borders), ethnicity, language barriers and learning difficulties. Much work will be done to reduce these inequalities through the action plan that NHS Borders will be producing in response to the PHS Equity in Screening Strategy.

Participants that receive a positive bowel screening result are normally referred for further investigation to endoscopy services within NHS Borders. Further investigation waiting times remain challenging, with the majority of patients within NHS Borders being referred between 4-8 weeks, whereas this should ideally be under 4 weeks. It should be noted that although these waiting times are challenging, Borders is still performing better than Scotland for bowel screening participants when it comes to colonoscopy investigation waiting times.

It is important that any tests a patient has are accurate and complete. Two programmes are worth noting here; within the AAA service, Borders had more USS encounters where the aorta could not be visualised compared to Scotland, and the colonoscopy completion rate in Borders was lower than Scotland.

Many of the issues highlighted within this report where NHS Borders does not appear to meet national standards or KPIs could be attributed to the Covid-19 pandemic, and backlog of patients as a result. Other barriers to meeting some of the standards include postal issues, or problems with national laboratories that are out of the control of the local board.

Data access and quality are another issue that has been flagged whilst compiling this report. There have been no formal published KPIs for the DES programme during the time period that this report is concerned with. This is not Borders specific - it is a national issue and due to a multitude of compounding factors including Covid-19, a new IT system, as well as a change to the screening pathway, all of which occurred in the last 3 years. A report is due next year, and locally, performance and safety is being managed with management performance data within the call-recall office.

Significant issues also exist with meeting the national standards for the Pregnancy and Newborn Screening programme in Borders. This has been raised before through the clinical governance and quality committee, however, the challenge remains around providing assurance of this programme due the scattered nature of the data across teams, systems and borders, as well as the fact that the maternity IT system (BadgerNet) is not set up in the most effective or efficient way to extract required information. Therefore, the task of measuring the performance of the programme requires a large amount of intense resource, which is not dedicated, and this remains a high risk to providing assurance to the board around the performance of this programme.

Finally, it is worth highlighting some of the areas of good practice that are being seen within the different programmes. Accessibility is being improved, with appointments being offered in different areas of the Borders where possible, as well as at different times of day and weekends. Within the DES programme, appointments are accommodated for inpatients in the BGH, and telephone contact made with invitees to reduce DNAs. There are initiatives which try to improve uptake of screening such as Confident Conversations, specific staff screening training, outreach community education sessions, and specific learning disability work to improve conversations around screening in this group, alongside more accurate recording of decision making.

In addition, given that screening provides the opportunity to meet and engage with those who may not otherwise attend a healthcare setting, it is important to note the huge number of potential encounters that the screening programmes in Borders offers. If everyone who was eligible for screening in the health board participated in the relevant programmes, this would equate to just over 180,000 points of contact over a 3 year period (see table 10 below). This is a fantastic example of ‘Making Every Contact Count’, where screening provides a platform to promote other areas of health and wellbeing, as well as sign-posting to local services.

Screening programme	Average number of eligible individuals in Borders in a screening cycle
AAA	859 yearly
Bowel	45,748 2-yearly
Breast	13,108 3-yearly
Cervical	27,523 yearly
DES	5,554 yearly
Pregnancy	974 yearly
Newborn	776 yearly

Table 10 Average number of eligible individuals for each of the screening programmes in Borders for a typical screening cycle

Looking forward

There are projects and developments occurring across many of the different screening programmes going forward.

In light of the National Services Division review of Breast Screening, the service has been considering what framework of services might best meet the needs of the South East Scotland population and demography. The conclusion is that the service would be very keen to lead on a trial of the Satellite Screening Centre concept, along with a pilot of post-code based invitation if that were feasible.

Nationally, there are new standards in consultation for the bowel screening programme. More locally, a bid was submitted for cancer research UK funding from Borders which has reached the final stages. The aim of this funding is to deliver and evaluate a targeted service innovation project to improve colorectal cancer outcomes.

The DES programme has launched a national appointment SMS reminder service, as well as online booking, but neither are yet to be implemented by NHS Borders or Lothian. There is also the aim for DES collaborative training for screeners (level 3 diploma) to recommence in 2024. In addition, NEC are developing a software tool to assist call-recall managers to smooth the distorted demand curve following Covid-19 recovery. There is also work in development around analysing and publishing KPIs for this programme, following the significant changes seen over the last 3 years.

Within the cervical screening programme there is a national audit ongoing, regarding women listed as having a total hysterectomy. There is also work in progress to create a colposcopy to SCCRS interface which will improve the quality of data in SCCRS and reduce the requirement

for duplicate data entry. Scottish Government is also awaiting the results of the NHS England self-sampling studies (HPValidate), to decide whether this should be incorporated into the national cervical screening programme. As mentioned previously, more locally work has begun on a new project related to defaulting on cervical screening during pregnancy.

Finally, a data quality project is being scoped out within pregnancy and newborn screening, with the hope that a public health practitioner within the team will spend time looking at the quality of the pregnancy and newborn data, leading to a discussion of the most effective and efficient ways of managing and reporting on this data going forward.

Recommendations

- Work is required around the data quality and availability for the pregnancy and newborn programme. The process and software needs to be reviewed, alongside possible training for those on the frontline around data entry into the IT system. Assurance of the performance of this programme remains challenging, dedicated resource should be part of this.
- Given the stark differences in uptake in most of the programmes across deprivation categories, wide buy-in from across the Borders is requested for both the Equity in Screening strategy action plan, and the Health Inequalities Strategy to ensure that these differences can be addressed in useful and enduring ways. These will include plans to improve uptake across all of the programmes, but particularly the cervical and DES programmes where uptake is below national targets.
- Continuation of quality of the AAA USS, and colonoscopy tests should be reviewed locally to decide if further training is required to improve non-completion rates.
- Waiting times for colonoscopy remains challenging, this should continue to be monitored closely with clear escalation routes.
- Await formally published KPIs for the DES programme, assisting the national process for this where necessary, and cascading the results once available.
- Overall strengthen the monitoring and evaluation of all of the programmes, with dedicated resource for each programme. This could be enhanced with use of IT and the development of screening dashboards which update regularly, and from which data can be pulled easily.

Appendices

Summary of NHS Borders AAA screening programme data, and performance against national standards (April 2020 – March 2023)

		Essential / Desirable	April 2020 - March 2021	April 2021 - March 2022	April 2022 - March 2023
1.1	Percentage of eligible population who are sent an initial offer to screening before age 66	Essential ≥ 90% Desirable 100%	99.50%	98.30%	100.00%
1.2a	Percentage of eligible population who are tested before age 66 and 3 months	Essential ≥ 75% Desirable ≥ 85%	87.90%	87.90%	
1.3a	Percentage of eligible population who are tested before age 66 and 3 months by Scottish Index of Multiple Deprivation (SIMD) quintile	Essential ≥ 75% Desirable ≥ 85%	1: 84.2% 2: 86.5% 3: 86.5% 4: 89.4% 5: 95.3%	1: 83.8% 2: 83.1% 3: 87.2% 4: 89.9% 5: 94.4%	
1.4a	Percentage of annual surveillance appointments due where men are tested within 6 weeks of due date	Essential ≥ 90% Desirable 100%	67.70%	96.30%	
1.4b	Percentage of quarterly surveillance appointments due where men are tested within 4 weeks of due date	Essential ≥ 90% Desirable 100%	68.80%	88.50%	
2.1a	Percentage of screening encounters where aorta could not be visualised	Essential < 3% Desirable < 1%	1.40%	6.20%	6.00%
2.1b	Percentage of men screened where aorta could not be visualised	Essential < 3% Desirable < 1%	1.00%	5.00%	
2.2	Percentage of images which did not meet the quality assurance audit standard and required immediate recall	Essential < 4% Desirable < 1%	3.00%	0.00%	
3.1	Percentage of men with AAA ≥ 5.5cm seen by vascular specialist within two weeks of screening	Essential ≥ 75% Desirable ≥ 95%	100.00%	N/A	N/A

3.20	Percentage of men with AAA ≥ 5.5cm deemed appropriate for intervention who were operated on by vascular specialist within eight weeks of screening	Essential ≥ 60% Desirable ≥ 80%	N/A	N/A	N/A
4.1	30-day mortality rate following open elective AAA surgery	Essential < 5% Desirable < 3.5%	2.1% all of Scotland 2016/17 - 2020/21		
4.2	30-day mortality rate following elective Endovascular Aneurysm Repair intervention	Essential < 4% Desirable < 2%	0% all of Scotland 2016/17 - 2020/21		

Summary of NHS Borders bowel screening programme data, and performance against national standards (1st Nov 2020 - 31st Oct 2022)

		Essential / Desirable	1st Nov 2020 - 31st Oct 2022
HIS Standard	Overall uptake of screening - percentage of people with a final outright screening test result, out of those invited	60% of men	69.30%
		60% of women	74.60%
HIS Standard	Overall uptake of screening by deprivation category: First quintile	60%	61.9%
	Overall uptake of screening by deprivation category: Second quintile	60%	66.8%
	Overall uptake of screening by deprivation category: Third quintile	60%	72.5%
	Overall uptake of screening by deprivation category: Fourth quintile	60%	74.5%
	Overall uptake of screening by deprivation category: Fifth quintile	60%	78.0%
	Percentage of people with a positive screening test result	N/A	2.80%
HIS Standard	Time from screening test referral date to date colonoscopy performed (95% in < 31 days)	95% in < 31 days	28.70%
	Percentage of people with a positive screening test result going on to have a colonoscopy performed	N/A	80.90%
HIS Standard	Percentage of people that had a completed colonoscopy	90%	92.80%
	Percentage of colonoscopic complications	N/A	0%
	Percentage of people that had a cancer detected	N/A	0.11%
	Percentage of people with colorectal cancer staged as Dukes' A	N/A	39%
	Percentage of people with colorectal cancer staged as Dukes' B	N/A	24.40%
	Percentage of people with colorectal cancer staged as Dukes' C	N/A	31.70%
	Percentage of people with colorectal cancer staged as Dukes' D	N/A	4.90%

	Percentage of people with colorectal cancer staged as Dukes' Not known	N/A	0%
	Percentage of people with colorectal cancer where the stage has not yet been supplied	N/A	0%
	Percentage of people with colorectal cancer that has a recorded stage	N/A	100%
	Percentage of people screened that had a polyp cancer detected	N/A	0.036%
	Percentage of cancers that were polyp cancers	N/A	31.70%
	Percentage of people with adenomas detected	N/A	0.845%
	Percentage of people with high risk adenomas detected	N/A	0.13%
	Positive Predictive Value for colorectal cancer	N/A	6%
HIS Standard	Positive Predictive Value for adenoma as the most serious diagnosis	35%	44.70%
	Positive Predictive Value for high risk adenoma as the most serious diagnosis	N/A	7.10%
	Positive Predictive Value for high risk adenoma as the most serious diagnosis or colorectal cancer	N/A	13.10%
	Positive Predictive Value for adenoma as the most serious diagnosis or colorectal cancer	N/A	50.70%
	Percentage of people with a colorectal cancer that is a malignant neoplasm of the colon	N/A	53.70%
	Percentage of people with a colorectal cancer that is a malignant neoplasm of the rectosigmoid junction	N/A	12.20%
	Percentage of people with a colorectal cancer that is a malignant neoplasm of the rectum	N/A	34.10%

Summary of NHS Borders breast screening programme data, and performance against national standards (April 2018 - March 2021)

		Essential / Desirable	April 2018 - March 2021
Attendance rate (percentage of women invited)		Essential ≥ 70% Desirable ≥ 80%	78.00%
Invasive cancer detection rate (per 1000 women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential ≥ 2.7 Desirable ≥ 3.6	6.80
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential ≥ 3.1 Desirable ≥ 4.2	7.10
Small (<15mm) invasive cancer detection rate (per 1000 women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential ≥ 1.5 Desirable ≥ 2.0	3.40
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential ≥ 1.7 Desirable ≥ 2.3	4.90
Non-invasive cancer detection rate (per 1000 women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential ≥ 0.5	0.70
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential ≥ 0.6	1.80
Standardised Detection Ratio (SDR) (observed invasive cancers detected divided by the number expected given the age distribution of the population)		Essential ≥ 1.0 Desirable ≥ 1.4	1.60
Recalled for assessment rate (percentage of women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential < 10% Desirable < 7%	6.40%
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential < 7% Desirable < 5%	2.90%
Benign biopsy rate (per 1000 women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential < 1.5 Desirable < 1.0	1.40
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential < 1.0 Desirable < 0.75	0.30

Summary of NHS Borders breast screening programme data, and performance against national standards (April 2020 – March 2022)

		Essential / Desirable	1st April 2020 to 31st March 2021	1st April 2021 to 31st March 2022
HIS Standard	Overall uptake of screening - percentage of people with a final outright screening test result, out of those invited	80%	74.60%	74.10%
HIS Standard	Overall uptake of screening by deprivation category: First quintile	80%	61.90%	65.14%
HIS Standard	Overall uptake of screening by deprivation category: Second quintile	80%	66.75%	71.84%
HIS Standard	Overall uptake of screening by deprivation category: Third quintile	80%	72.50%	74.65%
HIS Standard	Overall uptake of screening by deprivation category: Fourth quintile	80%	74.51%	75.09%
HIS Standard	Overall uptake of screening by deprivation category: Fifth quintile	80%	77.99%	80.02%

Summary of NHS Borders pregnancy and newborn screening programme data, and performance against national standards (April 2020 - March 2023)

		Essential / Desirable	April 2020 - March 2021	April 2021 - March 2022	April 2022 - March 2023
1.1	Haemoglobinopathies: Antenatal Coverage	≥ 95.0%/ ≥ 99.0%	73.93%	80.77%	78.85%
1.2	Haemoglobinopathies: Timeliness of antenatal screen	≥ 50.0%/ ≥ 75.0%	71.59%	76.92%	73.30%
1.3	Haemoglobinopathies: Completion of Family Origin Questionnaire	≥ 95.0%/ ≥ 99.0%	Unknown	Unknown	Unknown
1.4	Haemoglobinopathies: Timely offer of prenatal diagnosis (PND) to women at risk of having an affected infant	TBD	Unknown	Unknown	Unknown
1.5	Haemoglobinopathies: Timely reporting of newborn screen positive	≥ 90.0 % / ≥ 95.0%	Unknown	Unknown	Unknown

1.6	Haemoglobinopathies: Timely receipt into specialist care	≥ 90.0 %/ ≥ 95.0%	Unknown	Unknown	Unknown
2.1	Hepatitis B: Coverage	≥ 95.0%/ ≥ 99.0%	75.00%	84.00%	85.00%
2.2	Hepatitis B: Test turnaround time	≥ 95.0%/ ≥ 97.0%	Unknown	Unknown	Unknown
2.3	Hepatitis B: Treat/Intervene	≥ 97.0%/ ≥ 99.0%	Unknown	Unknown	Unknown
2.4	Hepatitis B: Timely assessment of woman with Hepatitis B	≥ 70.0%/ ≥ 90.0%	Unknown	Unknown	Unknown
2.5	Hepatitis B: Timely neonatal vaccination and immunoglobulin	≥ 97.0%/ ≥ 99.0%	Unknown	Unknown	Unknown
3.1	Congenital Syphilis: Coverage	≥ 95.0%/ ≥ 99.0%	75.00%	84.00%	85.00%
3.2	Syphilis: Test turnaround time	≥ 95.0%/ ≥ 97.0%	Unknown	Unknown	Unknown
3.3	Syphilis- Treat/Intervene	≥ 97.0%/ ≥ 99.0%	N/A	N/A	N/A
4.1	HIV: Coverage	≥ 90.0%/ ≥ 99.0%	75.00%	84.00%	85.00%
4.2	HIV: Test turnaround time	≥ 95.0%/ ≥ 97.0%	Unknown	Unknown	Unknown
4.3	HIV: Treat/Intervene	≥ 97.0%/ ≥ 99.0%	N/A	N/A	N/A
5.1	Down's syndrome: Coverage	N/A	N/A	N/A	N/A
5.2	Down's syndrome screening: Test turnaround time	First Trimester: Only available for all of Scotland			
		Second Trimester: Only available for all of UK			
5.3	Down's syndrome screening: Completion of laboratory request forms	≥ 97.0% / 100.0%	First Trimester: 97.6%	First Trimester: 98.3%	First Trimester: 99%
			Second Trimester: 96.7%	Second Trimester: 98.4%	Second Trimester: 96.8%

5.4	Down's syndrome screening: Time to intervention	≥ 97.0% / ≥ 99.0%	Unknown	Unknown	Unknown
5.5	Down's syndrome screening: Test performance – Screen Positive Rate (SPR) singleton pregnancies only	First Trimester: 1.8-2.5% / 1.9-2.4%	2.60%	3.60%	3.12%
		Second Trimester: 2.5-3.5%/ 2.7-3.3%	Second Trimester: 2.36%	Second Trimester: 0%	Second Trimester: 1.59%
5.6	Down's syndrome screening: Test performance – Detection Rate (DR)	Only available for East of Scotland			
5.7	Down's syndrome screening: Diagnose	N/A			
6.1	Fetal Anomaly: Coverage of the fetal anomaly ultrasound	≥ 90.0%/ ≥ 95.0%	75.00%	75.00%	69.00%
6.2	Fetal Anomaly: test performance of the fetal anomaly ultrasound	≥ 50.0% for each serious cardiac anomaly	Unknown	Unknown	Unknown
6.3	Fetal anomaly: Time to intervention (18+0 to 20+6 fetal anomaly ultrasound)	≥ 97.0%	Unknown	Unknown	Unknown
6.4	Fetal anomaly: Diagnose	90.00%	Unknown	Unknown	Unknown
7.1	The proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks corrected age.	> 98% / > 99.5%	96.76%	97.56%	97.43%
7.2	The proportion of well babies tested using the AOAE protocol who do not show a clear response in both ears at AOAE1.	< 27% / < 22%	N/A	N/A	N/A
7.3	The proportion of well babies tested using the AOAE protocol who do not show a clear response in both ears at AOAE2.	< 6% / < 5%	N/A	N/A	N/A

7.4	The proportion of well babies tested using the AABR protocol who do not show a clear response in both ears at AABR1.	< 15% / < 12%	2.17%	0.46%	0.76%
7.5	The proportion of babies with a screening outcome who require an immediate onward referral to audiology for a diagnostic assessment.	< 3% / < 2%	2.14%	0.45%	1.00%
7.6	The proportion of babies with a no clear response result in in one or both ears or other result that that requires an immediate onward referral for audiological assessment who receive an appointment for audiological assessment within the required timescale (within 4 weeks of screen completion or by 44 weeks gestational age).	> 97% / > 99%	66.67%	0.00%	25.00%
7.7	The proportion of babies with a no clear response result in in one or both ears or other result that that requires an immediate onward referral for audiological assessment who attend for audiological assessment within the required timescale (within 4 weeks of screen completion or by 44 weeks gestational age).	> 90% / > 95%	55.56%	0.00%	25.00%
8.1	Newborn Blood Spot: Coverage (NHS Board responsibility at birth)	≥ 95.0% / ≥ 99.0%	97.12%	97.80%	94.49%
8.2	Newborn Blood Spot: Coverage (Movers in)	≥ 95.0% / ≥ 99.0%	100.00%	93.33%	88.00%
8.3	Newborn Blood Spot: Avoidable repeat tests	≤ 2.0% / ≤ 1.0%	4.90%	3.38%	5.79%
8.4	Newborn Blood Spot: Timely identification of babies with a null or incomplete result recorded on the Child Health Information System (CHIS)	Ideally daily, minimum weekly	Twice a week (run on a Friday, downloaded on a Monday, and run on a Wednesday, downloaded on a Thursday)		
8.5	Newborn Blood Spot: CHI number is included on the bloodspot card	≥ 98.0% / ≥ 100.0%	98.60%	99.21%	99.40%
8.6	Newborn Blood Spot: Timely sample collection	≥ 90.0% / ≥ 95.0%	95.90%	96.91%	97.33%

8.7	Newborn Blood Spot: Timely receipt of the sample in the laboratory	≥ 95.0% / ≥ 99.0%	84.33%	92.65%	83.46%
8.8	Newborn Blood Spot: Timely taking of a second bloodspot sample for CF screening	≥ 95% / ≥ 70%	0.00%	100.00%	100.00%
8.9	Newborn Blood Spot: Timely taking of a second bloodspot sample following a borderline CHT screening	≥ 95.0% / ≥ 99.0%	100.00%	100.00%	100.00%
8.10	Newborn Blood Spot: Timely taking of a second bloodspot sample for CHT screening for preterm infant	≥ 95.0% / ≥ 99.0%	42.86%	33.33%	30.00%
8.11	Newborn Blood Spot: Timely processing of CHT and IMD (excluding HCU) screen positive samples		100.00%		
8.12	Newborn Blood Spot: Timely entry into clinical care		100.00%		

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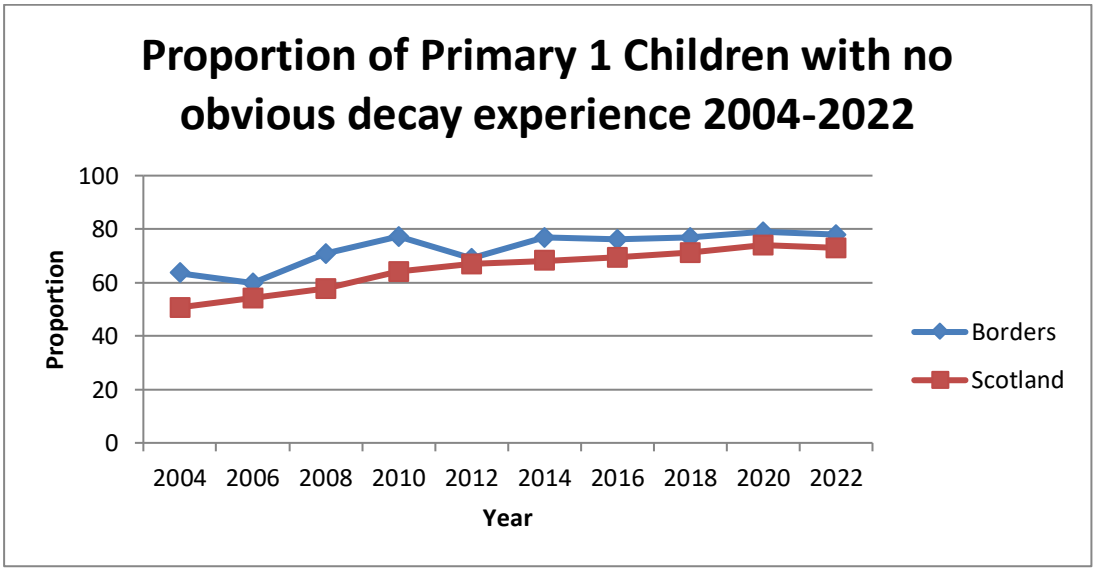
Oral Health / Dental Public Health Report

Oral Health

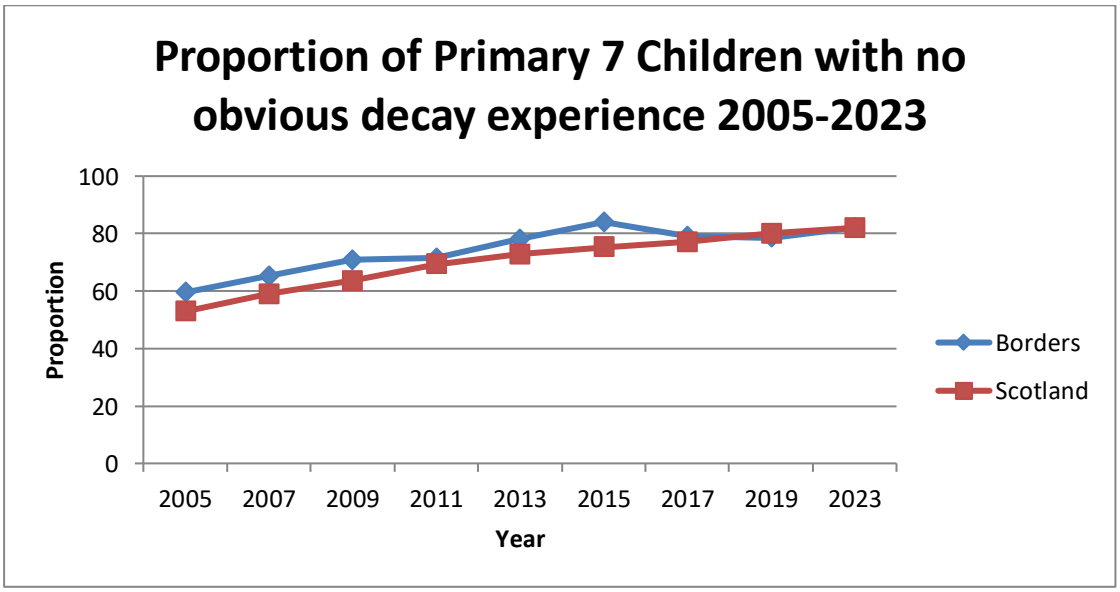
Our most robust data on oral health are gathered annually through the National Dental Inspection Programme (NDIP) of children in Primaries 1 and 7. In general the oral health of children in The Borders is good with the proportion of children with no obvious decay experience regularly higher than the national average as shown in Figures 1 and 2 below.

Figure 1 – Proportion of P1 children with no obvious decay experience



Public Health Scotland

Figure 2 – Proportion of P7 children with no obvious decay experience

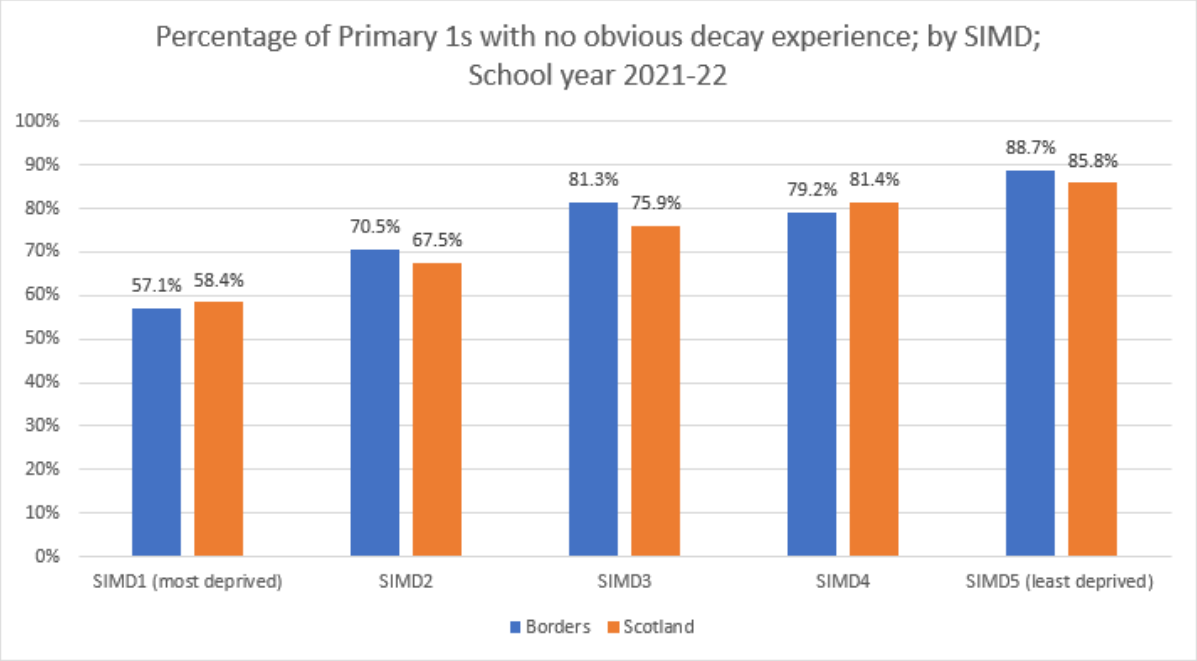


Public Health Scotland

The most recent NDIP report (school year 2022-23) shows that in the Borders 82% of Primary 7 children had no obvious decay experience, which is comparable to Scotland as a whole. This is encouraging and is a marked improvement on 2005 when these figures were only 59.5% in The Borders and 52.9% in Scotland, however almost 20% of children do still experience dental decay and action is required to bring this down further.

We know that children living in areas of deprivation are at increased risk of dental decay and analysis of the P1 NDIP data from 2021-22 at Health Board level (Figure 3) demonstrates the gradient between oral health of children living in the most and least deprived areas in The Borders. Any action to reduce decay experience must therefore focus on supporting those at greatest risk.

Figure 3 – Primary 1 "no obvious decay experience" by SIMD, Borders and Scotland



Public Health Scotland

Adult oral health has also improved though data are less readily available. We know that these improvements mean that many more adults are retaining their own teeth into older age. While this is hugely positive, it does generate an increased need for dental care, including for teeth which have undergone complex restorative treatment and require ongoing maintenance. Additional complexities arise as this ageing dentate population develop co-morbidities, frailty or dependencies which can impact on provision of dental care and ability to maintain oral health on a day-to day basis.

Dental Services

Dental services in The Borders continue to operate under significant pressure. A national shortage of dental professionals has compounded longstanding recruitment challenges in

the area, impacting on the availability of dental services. Emergency dental care remains available to anyone with an urgent dental problem, either through their usual dentist or, if unregistered, through the Borders Emergency Dental Service.

As at 30th September 2022, 83.4% of children and 84.4% of adults in the Borders were registered with an NHS dentist, slightly lower than the national average of 87.2% of children and 97.3% of adults. Recent access challenges have seen a reduction in the numbers of young children registered with an NHS dentist, most likely because very few practices have been accepting new patients since many of these children were born.

The majority of NHS dental care is delivered by independent dental contractors in the General Dental Service (GDS) ("high street" dental practices). The Public Dental Service (PDS) has a remit to provide dental care for vulnerable populations who cannot be treated in routine general dental services. In the Borders the PDS have played a valuable role in delivering access to dental care for members of the general population where availability of GDS has not been able to meet the level of demand. As access challenges have increased, it is important that PDS capacity is managed to ensure that those most in need of this service are prioritised.

Over the past 18 months two new NHS general dental practices have opened in The Borders which has helped to increase capacity, though levels of demand remain high. A new system for NHS dental care was introduced in Scotland on 1st November 2023. This has facilitated a move to a more patient centred approach with recall intervals (time between check ups) tailored to the individual patients' oral health status and a simplification of the fee structure. It remains early days for this new system but it is hoped that this will bring increased stability to the sector and over time support increased access to NHS dental care.

Prevention

As with many other aspects of health, the most important factors for maintaining good oral health sit outwith healthcare or dental services. On a day to day basis brushing teeth at least twice a day with fluoride toothpaste, eating a diet low in sugar, avoiding smoking and limiting alcohol intake will help prevent dental problems. These factors become even more important in times when dental services are under extreme pressure.

Recognising that for some people their life circumstances can place them at increased risk of poor oral health, NHS Borders have an active Oral Health Improvement Team who work closely with various partners and agencies to help create environments which support oral health. The main body of work for the team is delivery of the five national oral health improvement programmes:

Childsmile – for children, taking a proportionate universalism approach to improve the oral health of all children, with a particular focus and enhanced input for those at greatest need. Childsmile work closely with dental services, health visitors, education establishments and

other children's services supporting toothbrushing in the home and through supervised toothbrusing programmes as well as offering advice and support to families and encouraging dental attendance.

Open Wide – for adults with additional care needs. Since the national programme was launched in 2019 the team in NHS Borders have developed strong networks with support agencies as the programme becomes established. Oral health support and advice, including toothbrushing are supported

Caring for Smiles – for dependent older people. Focussed initially on care homes, the programme provides training to care staff to enable them to deliver daily oral care to maintain healthy mouths for those who require support with this important task. The NHS Borders team actively seek to expand the reach of the programme working with care homes but also across other health and care settings

Mouth Matters – for people in prison and **Smile4Life** for people experiencing homelessness are delivered in parallel with a focus on the most vulnerable communities through working with partner agencies such as the Dept of Work and Pensions, addictions services and other local groups.

Despite a pause in these programmes when staff were redeployed to other areas during the COVID pandemic, remobilisation of the programmes has been very successful and the team constantly seek to expand and develop to deliver the best possible support and prevention of dental disease.

Strategic Direction

In response to an oral health needs assessment undertaken in 2018, a Strategic Plan for Oral Health and Dental Services is in advanced stages of development and will be implemented from April 2024. The overarching twelve year plan will be divided into three yearly action plans. The plan will deliver on four key themes based on the ten priorities identified by the needs assessment as outlined in Figure 4 below.

Figure 4 – Vision, Themes and Priorities for NHS Borders Strategic Plan for Oral Health and Dental Services 2024-36

OUR VISION:

Everyone in the Borders will enjoy excellent oral health as a key part of their overall health and wellbeing.

THEMES	Maximising oral health	Access to dental care	Developing pathways	Partnership working
PRIORITY ACTIONS	Raising the profile of oral health	Maintaining and improving access	Meeting the needs of ageing patients	Raising the profile of oral health
	Maintaining and improving oral health	Encouraging recruitment and retention	Meeting the needs of dental priority groups	Maintaining and improving oral health
	Meeting the needs of ageing patients	Developing the role of the Public Dental Service	Developing the Public Dental Service workforce	Meeting the needs of ageing patients
	Meeting the needs of dental priority groups		Developing patient pathways to dental services	Meeting the needs of dental priority groups
	Networking and engagement with dental teams and wider partners			Networking and engagement with dental teams and wider partners

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Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 March 2024

PUBLIC PROTECTION ANNUAL REPORT

Report by **Rachel Pulman- Nurse Consultant Public Protection**

1. PURPOSE AND SUMMARY

1.1 The report is being brought to the IJB for awareness.

1.2 'Everybody in the Scottish Borders has the right to live safe from abuse, harm and neglect' (Public Protection Committee Vision statement)

1.3 NHS Borders and the NHS Borders Public Protection team continue to promote the key principle that Child and Adult Support and Protection is 'Everyone's Responsibility'.

1.4 Public Protection (PP) practice continues to be emotive, complex and challenging particularly against the backdrop of the economic climate and resource demand versus staffing capacity. This challenges services to ensure that collaborative partnership working continues to be a critical factor in protecting those at risk of harm, abuse or neglect.

1.5 NHS Borders (NHSB) have specific responsibilities and work along with the Scottish Borders Partnership to report progress and ensure evidence of continuous improvement for both Child Protection and Adult Support and Protection.

1.6 The NHS Borders Public Protection (PP) team continue to provide specialist and expert public protection advice, support, supervision (key staff) and training to staff across the organisation to support them to fulfil their responsibilities and duties in respect to a wide range of public protection issues across the life span.

1.7 The NHSB PP team is committed to ensure that all Public Protection process, particularly in relation to child and adult support and protection are robust and effective and that we are responsive to emerging local and national needs and initiatives. Most importantly we aim to ensure that the person at risk of harm remains at the centre and that their voice is heard and a culture of learning is promoted.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) Note the report. The Underpinning message is that Child and Adult Support and Protection is everyone's business irrespective of role or position in NHS borders.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
X		X		X	

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
X	X	X	X	X	

4. INTEGRATION JOINT BOARD DIRECTION

4.1 A Direction is not required.

5. BACKGROUND

5.1 There are several key pieces of legislation, policy and guidance that outline duties and responsibilities and support the delivery of Public Protection Services including;

Children and Young People (Scotland) Act 2014
Getting it right for every child (GIRFEC)
National guidance for child protection in Scotland
Adult Support and Protection (Scotland) Act 2007
Adults with Incapacity (Scotland) Act 2000
Mental Health (Care and Treatment) Scotland Act 2003
Equally Safe Strategy 2018
Multi-Agency Public Protection Arrangements (MAPPA): National Guidance 2022
PREVENT Guidance 2021
Adult Support and Protection (Scotland) Act 2007 - Code of Practice
National guidance for child protection committees undertaking learning reviews
Guidance for Adult Protection Committees to use when considering or undertaking learning reviews.

6. Scottish Borders Joint Inspections

Joint Inspection Adult Support and Protection

6.1 A significant focus over the last year has been in relation to inspection activity.

6.2 Following the positive inspection report for Adult Support and Protection the Scottish Minister for Social Care, Mental Wellbeing and Sport, Maree Todd visited the Scottish Borders Public Protection Unit and met meet with members of the Chief Officer Group; senior managers; frontline managers

and staff, and service users. Following the visit The Minister expressed her thanks and commented that;

6.3 *'The Scottish Borders Adult Support and Protection Inspection report found that the partnership had major strengths in strategic leadership and ASP processes, which in turn facilitated positive experiences and outcomes for adults at risk of harm. I was interested to hear about the work the partnership has done to merge Child Protection and Adult Support and Protection into a Public Protection partnership approach which, through multi-agency working and co-location, enables a positive culture between senior leaders and staff. As we know, Adult Support and Protection is a vital part of supporting the vision as we work together to improve the lives of people in Scotland. Adults at risk of harm must be at the heart of decisions, and their voices heard when shaping services. In this aspect, Scottish Borders partnership is a shining example of excellent practice.'*

6.4 The Joint Inspection of Adult Support and Protection Overview report (Aug 2023) only one Partnership Area, Scottish Borders, out of all 25 inspected since the start of the pandemic, were measured as 'Very effective in operational Key Processes' and 'Very effective in Strategic Leadership'. There are several comments in the report directly attributable to Scottish Borders, and we are now cited in national conversations as a best practice example for Scotland by the Inspectorate.

Scottish Borders joint inspection children at risk of harm.pdf (careinspectorate.com)

6.5 The aim of the Joint inspection was to provide assurance on the extent to which services in Scottish Borders were working together, to demonstrate that:

1. Children and young people are safer because risks have been identified early and responded to effectively.
2. Children and young people's lives improve with high quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm.
3. They influence service planning, delivery and improvement.
4. Collaborative strategic leadership, planning and operational management ensure high standards of service delivery

6.6 The inspectors found 'important strengths that had significant positive impacts on children and young people's experiences' and evaluated 'impact on children and young people' as good.

6.7 Strengths highlighted in the report include:

- Children, young people and families benefited from supportive and trusting relationships with staff across services.
- The recognition and initial response to risk and concern to children was a strength. Staff took timely and appropriate action to keep children safe.
- Pregnant women and very young babies received help and support at an early stage as a result of timely referrals from pre-birth services
- Well-established collaborative working across services ensured children and young people benefited from timely responses to identification of risks.
- Nurturing and trauma informed services provided a range of supports to help children and young people recover from abuse, neglect and trauma. Some of these services were not consistently available when children and young people needed them.
- Children, young people and parents and carers were supported to meaningfully contribute to decisions about their lives by compassionate staff.
- Evidence of strong partnership working, and staff and leaders demonstrating commitment to improving outcomes for children, young people and families.

6.8 The report also highlighted areas for improvement which include;

- Strengthening quality of chronologies and children's plans.
- Ensuring that the voice of children and families are routinely and meaningfully influenced service planning and improvement.
- Strengthening the partnership's approach to improvement and change to ensure a shared and systematic approach to quality assurance and self-evaluation.

6.9 Scottish Borders Partnership have developed an Improvement plan (submitted to Care Inspectorate 04/07/23) that details how the key areas identified will be prioritised to evidence continued improvement. The care inspectorate will offer support for improvement and monitor progress though our linking arrangements.

6.10 Work is already underway in relation to the opportunities for improvement including the transition into a new structure with the aim of streamlining strategic groups and to improve connections within the planning structures for Children Services and development of joint quality assurance and self evaluation processes to maximise the impact of services on children and young people.

6.11 The positive findings highlighted within both inspection report's reflect the hard work, knowledge and skills and commitment of staff within NHS Borders and across the partnership.

7. ASSESSMENT

7.1 Governance, accountability, quality assurance and reporting arrangements for protecting children and adults are in place across the organisation.

- The Governance, accountability and reporting arrangements for Public Protection in Scottish Borders are place.
- Chief Executives of Health Boards are the Chief Officers responsible for ensuring that their organisation works individually and in partnership, to protect individuals who may be at risk of harm.
- The Chief Executive has delegated responsibility for Public Protection to the Nurse Director; the Nurse Consultant PP is responsible for leadership, co-ordination and management of PP services.
- Nurse Consultant PP advises and escalates any risks regards Child and Adult Support and Protection matters to the Director of Nursing and/or Associate Director of Nursing for the relevant clinical board area.
- There are named professional who have specific roles and responsibilities for Public Protection work; these roles are fulfilled and in place.
- Quarterly ASP and CP performance reports are shared with Critical Services Oversight Group (CSOG) and PPC who provide oversight and scrutiny to key performance indicators. The report considers 5 performance indicators;
    - Involved: Considers the volume of cases involved in the ASP/CP processes. Demonstrates services demand
    - Other services: What Input is provided by different partners
    - Characteristics: Vulnerabilities; the who/where/why. Builds a picture of what is happen within the services.
    - Assessing: Local responses and process effectiveness. Are local and statutory obligations being met.
    - Impact: Measure of impact of the intervention.
    -

- IRD review group: Nurse Consultant PP, Group Manager CP, Inspector Police Scotland and Lead Officer PP review all IRDs to ensure satisfied decision making has been robust and actions completed; also identifies areas for improvement/practice development.
- In response to the publication of the NHS Public Protection Accountability and Assurance Framework 2022 the Lead Nurse's for Child and Adult Support and Protection convened a Short Life Working Group(SLWG) to develop and agree a standardised self-evaluation toolkit to support effective measurements of the public protection arrangements of NHS Boards in respect of Child Protection, Adult Support and Protection and Multi-Agency Public Protection Arrangements. NHSB is involved in a test of change for this project.

8. PREVENT

8.1 Prevent is part of the government counter terrorism strategy- Contest and aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism.

8.2 In Scotland, PREVENT delivery is overseen and supported by the Safeguarding and Vulnerability Team (SVT) at the Scottish Government. This team is the point of contact with the UK Government regarding delivery in Scotland and also administers the governance arrangements of PREVENT in Scotland.

8.3 Under the Prevent duty, NHS Borders is required to ensure that healthcare workers are able to identify early signs of an individual being drawn into radicalisation (*Process by which a person adopts extremist views or practices to the point of legitimising the use of violence*) and be able to respond and refer appropriately.

8.4 Healthcare staff will meet and treat people who may be vulnerable to being drawn into terrorism and as such it is a public protection issue that they must be aware of.

8.5 SVT have developed a Prevent annual assurance process and NHS Borders will now be expected to complete an annual return and RAG rate organisational compliance.

9. Current position of NHS Borders

9.1 There is work that needs to be progressed to ensure we are fully compliant with the Prevent duties. NHS Borders submitted first annual return July 2023 (see appendices);

- The Executive Lead for Prevent is Director of HR, OD,OH&S (added to portfolio June 2023) and the Single Point of Contact (SPOC) is the Nurse Consultant for Public Protection.
- NHS Borders PP team provides advice and support for NHS Borders staff who have concerns that somebody is at risk of radicalisation.
- NHS Borders has representation at East Region CONTEST meeting and Prevent SPOC network.
- An NHS Borders Prevent policy is being developed for use across NHS Borders.
- Prevent Multi agency information agreements in place, for reporting concerns and information sharing in line with Child and Adult Support and Protection.
- Currently all NHSB staff complete a Public Protection e-learning module which includes information about PREVENT and links to UK Home Office training.
- There is information available to staff on the intranet Prevent and ASP/CP pages.
- Key staff have attended Prevent Multi-agency Panel Training and Multi-agency links are in place.
- There is a need to revisit staff awareness/knowledge of roles and responsibilities.
    - The current training arrangement does not allow NHSB to capture how many staff complete the UK Home Office training. Going forward assurance is required that staff members are receiving the appropriate level of PREVENT training and are confident in identifying suspected signs of radicalisation.

- Proposal to be presented to NHSB Training & Education Board, for UK Home Office training module to be added to internal e-learning platform. This will facilitate tracking of staff completing the training. As well as ensuring that all NHSB staff have access to relevant PREVENT awareness training commensurate to their role and responsibility.

10. National Referral Mechanism

10.1 The National Referral Mechanism is a national framework that focuses on improving the identification of victims of human trafficking and exploitation and the support available to help them to safety and recovery.

10.2 The National Referral Mechanism (NRM) Toolkit for First Responders in Scotland was commissioned to improve the formal identification of victims through the National Referral Mechanism in Scotland and ensure that both frontline staff and potential victims are clear on the process and possible outcomes of this national pathway to identification and protection.

10.3 The Scottish Borders Partnership, including NHSB, has been involved in a NRM implementation pilot to evaluate the structured implementation of the toolkit for First Responder agencies in Scottish Borders by providing a framework linking strategic leadership to frontline practice and protocol development. Outputs include:

- A structured action plan detailing key steps in the implementation of the NRM Toolkit including key communication and engagement with stakeholders.
- Identification of a First Responder team within the Public Protection Unit.
- Development of locally agreed Human Trafficking Protocol including NRM process/flowchart.
- Tiered training including First Responder training on the use of the NRM process to support effective referrals.
- Wider workforce awareness sessions on Human Trafficking and locally agreed protocols.
- Suite of guidance documents to support and effective response to human trafficking in Scottish Borders to include interagency guidance/quick guides and briefings.

10.4 There have been three Human Trafficking Awareness sessions delivered, to support staff to recognise, respond and report concerns; 45 key staff across NHSB have attended.

- **NHS Borders is committed to identifying and responding to concerns about children and young people and Adults and has systems in place that direct staff to the actions they need to.**

- Child Protection and ASP policies, protocols and guidance are up to date and accessible to all staff, on NHSB Borders Intranet, to support them in the responsibilities they have for protecting children and adults.
- There is clear information about how to make a child and/or ASP referral on the intranet and how to seek advice/consultation.
- There are processes in place to enable Specialist Medicals and Health Assessments for Children and YP.
- The Lead paediatrician for Child Protection, who is responsible for Child Sexual Abuse Examinations(CSE), is on extended leave and during this period cover in relation to these duties is being provided via NHS Lothian.

- **There are strategic and operational arrangements in place between NHS Borders and multiagency partners to improve joint working and communication regarding children and young people and adults across agencies; think family.**

- The NHS Borders PP team continue to contribute to the operational and strategic functioning of the Multi-Agency Public protection Unit.
- There is a Public Protection Communication Delivery group that ensures a coordinated approach to the dissemination of key information to ensure a consistent approach to messaging.
- Staff from the Health and Social Care Partnership, including staff from public protection services, attended a workshop in May to discuss the development of a Capacity Pathway. This followed work undertaken to review and update the partnership's existing Capacity Assessment Tool (CAT). The aim of the workshop was to develop a Capacity Pathway across NHS and SBC and to jointly agree a flowchart and improved system of progressing Capacity-related situations in hospital, at home and in situations which require intervention under formal Adult Support & Protection. NHSB is progressing a parallel piece of work to develop a pathway of referral once it has been assessed that a Medical Assessment of Capacity is indicated.
- A Multi-Agency Short Life Working Group(SLWG) has been established to progress work in relation to strengthening chronologies, analysis and professional curiosity with Child and Adult Support and Protection Processes as per CP and ASP Improvement plans.
- NHSB are represented on a number of Multi-Agency strategic and operational groups in relation to Public Protection Practice.
- A Multi-Agency SLWG has been established to review current data collection processes and establish a consistent approach to reporting, Joint self-evaluation and practice development.
- A multi-agency group of staff from the Public Protection Unit have been reviewing the revised National Child Protection Guidance along side our current Scottish Borders CP Procedures to identify what changes are required to ensure we align with the updated guidance and are now progressing to writing the new version of the Scottish Borders Child Protection Procedures and creating an implementation plan. The main areas for change are in relations to:
    - Use of terminology
    - Changes to timescales for some meetings and associated reports
    - Improvements to the role of core group

10.5 As we progress with writing the content, we will be talking to front line practitioners from across all agencies about specific aspects, to make sure we get it right.

NB: The current CP procedures remain fully operational.

- **NHS Borders PP team ensure the establishment and maintenance of robust information sharing processes and procedures with regards to child and adult protection;**

10.6 There are established information sharing processes in place to share information in relation to Public Protection.

- A new alert process has been introduced on EMIS and Trac to flag to staff when an Adult or Child is subject to a CP or ASP investigation.
- Processes are in place to ensure that appropriate, relevant and proportionate information is shared in relation to MAPPA nominals.

10.7 **NB**: The number of different patient management systems in place across NHS Borders presents a challenge in ensuring relevant and proportionate information is shared/documented across all these systems.

- **NHS Borders has arrangements in place that provide support and supervision to staff working with vulnerable children, young people and families.**

- NHSB Public protection team continue to provide consultation for staff on Child and Adult Support and Protection matters.

- Child Protection Supervision is available and accessed as per child protection supervision policy.
- Child Protection Supervisor training (x2 Day/March 2023) was commissioned and delivered by an external trainer to **16** staff across health visiting/school nursing and Midwifery Service. This has supported us to develop skilled supervisors and enables us to continue to develop a consistent approach and understanding of what constitutes effective child protection supervision and its relationship to safe practice and positive outcomes for children and adults.

- **NHS Borders will ensure that Training and Development opportunities are available and accessible to support staff to fulfil roles and responsibilities for Public Protection.**

- NHSB is committed to promoting a learning culture that ensures that gaps in protection services and systems, which may adversely impact on the outcomes for children, YP and adults are identified and addressed.
- Systems are in place to deliver single and multi-agency training on Public Protection across NHSB.
- Mandatory Public Protection e-learning module August 2023 **80.8**% compliance for completion.
- NHS Borders staff across a broad spectrum of disciplines attended Multi-Agency Public Protection Training.

11. Developments from audit and practice reviews

11.1 A Case review in 2022 identified that there was a need to strengthening early recognition and response to vulnerability and risk pre-birth across midwifery services.

12. Actions

- Learning from review was shared with midwifery staff and training was delivered to Midwives specifically about identifying and responding to risk in ante-natal period.
- Attendance by PP team at team meeting liaison with Associate Director of Nursing for MW.
- A pre-birth section for the keeping children safe and well tool was developed and introduced to support assessment of risk (This tool is guidance to support all agencies to gauge appropriate levels of support and protection using 'stages' that correspond to the 4 Staged Model of Support); evaluated well by midwifery staff.
- SOP developed for Health Visiting and Midwifery service when non-engagement or unseen; particularly in relation to home visit (linked to HV pathway visit). This ensures that HV and/or MW will see and assess home environment in antenatal period.
- NHS Borders Unseen Child Policy updated to include unborn child.
- Pre-Birth Multi-Agency oversight group (includes Midwifery, CP/PP Nurse, Family Nurse, Duty SW team leader)- has oversight of all referrals made to Children and Families Duty Team and ensure that referrals have progressed and/or that appropriate assessments and plans are in place also ensure timescales are being met. Recently introduced review at 24 and 32 weeks.

13. Impact:

- Increase in timely referrals from midwifery service in respect to concerns pre-birth. When initial referral is made a date/invite is also provided for an initial pre-birth MAC. This increases opportunity to gather information, make assessment of risk and inform planning with women and families.
- **Referrals made by midwifes** 2019 -16 2020-34 2021-45 2022-46.
- Improvement in documentation and referral information on Badgernet.
- Increased use of Child Protection consultation by midwifery service.

13.1 There is still work ongoing to continue to strengthen pre-birth assessment and planning processes across multi-agency partners to ensure that assessment and planning commence as early as possible, this includes the development of 'Multi-Agency Pre-Birth Guidance'

14. Learning from other Board Areas

14.1 We have used learning from a Significant Case Review in another area of Scotland for an infant who died from traumatic brain injury to review our own internal processes. This included;

- Reflective learning session with Health visitors and midwives and paediatric nursing teams. Consultant Paediatrician also gave a learning session to Doctors.
- Feedback from staff was that the reflective session made then consider their own practice and assessments. Particularly re how fathers are included.
- Development of SOP for measurement of OFC and management of colic
- Messaging to parents re management of crying baby

15. Learning Reviews and Large Scale Inquires

15.1 A Multi-Agency Learning Review Delivery Group (sub-group of PPC) has been established to ensure that there is robust governance in respect to the commissioning and embedding from Learning Reviews.

15.2 There has been two Multi-Agency Learning Reviews, in respect to Adult Support and Protection cases, requested and approved by the Public Protection Committee**.** An external reviewer has been commissioned to undertake one and the other will be undertaken by a reviewer within SBC.

15.3 There has been one Large Scale Investigation commenced in Jul 2023.

16. IMPACTS

Community Health and Wellbeing Outcomes

16.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	x
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	
5	Health and social care services contribute to reducing health inequalities.	x
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	
7	People who use health and social care services are safe from harm.	x
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care	

	and treatment they provide.	
9	Resources are used effectively and efficiently in the provision of health and social care services.	

Financial impacts

17.1 There is no additional budget other than allocated to PP posts.

17.2 The current team continues to work at capacity which impacts on the ability to respond to aspects of work such as quality assurance, training and practice development versus the need to meet operational demand. There are also wider influences on the multi-agency response to Child and Adult Support and Protection in relation to the service demands and recruitment challenges our social work colleagues are facing.

17.3 The work of public protection is emotive and at times upsetting and disturbing as such it is important that, as a team, we take time to reflect and acknowledge this in our day to day and are mindful of each other's wellbeing as a team.

Equality, Human Rights and Fairer Scotland Duty

18.1 N/A.

Legislative considerations

19.1 Assurance that structures and processes are in accordance with national legislation, procedures and guidance.

19.2 PP operates within a series of complex adaptive systems, many of which continue to experience change as a result of changes in legislation and national guidance and the impact of societal changes.

Climate Change and Sustainability

20.1 N/A.

Risk and Mitigations

21.1 The economic climate and changes in the way we deliver PP services have resulted in increased demand on current workforce. Workforce discussions are on-going with DoN to ensure we continue to deliver safe and effective service responses to PP.

22. CONSULTATION

Communities consulted

22.1 N/A.

Integration Joint Board Officers consulted

IJB Chief Officer.

Approved by:

Sarah Horan- Director of Nursing, Midwifery and AHPs

Author(s)

Rachel Pulman- Nurse Consultant Public Protection

Background Papers:

Previous Minute Reference: N/A.

For more information on this report, contact us at Rachel Pulman, Nurse Consultant Public Protection
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PREVENT Annual Assurance Return Questions 2023 – Health

The PREVENT Duty under the Counter-Terrorism and Security Act 2015 requires all specified authorities to have "due regard to the need to PREVENT people from being drawn into terrorism". Your sector and their partners have a core role to play in countering terrorism and helping to safeguard individuals at risk of radicalisation and are therefore essential to the success of the programme.

National security and counter-terrorism are reserved functions, and as such the PREVENT Duty is established by the UK Parliament who oversee delivery in Scotland. However, the functions responsible for the delivery of PREVENT in Scotland are all devolved. As a result of this, there is a key role for Scottish Ministers who are consulted with regard to statutory guidance for PREVENT and in holding to account and supporting devolved functions in the delivery of PREVENT, despite the Scottish Government not being a specified authority under the Act.

In Scotland, PREVENT delivery is overseen and supported by the Safeguarding and Vulnerability Team (SVT) at the Scottish Government. This team not only is the point of contact with the UK Government regarding delivery in Scotland, but administers the governance arrangements of PREVENT in Scotland and provides support for practitioners across all specified authorities in Scotland.
Your input is essential to ensuring PREVENT is delivered appropriately by assessing local risk, supporting successful interventions through PMAP, building trust with communities, and ensuring sectors are aware of how and when to make a referral. Sharing best practice across sectors – whether via regional networking events, PREVENT governance structures, written communications/ newsletters - has been vital to the continuous improvement of delivery, helping practitioners share innovative projects, unblock barriers to success and reduce the risk of radicalisation in our communities. To extend this drive for continuous improvement, SVT have developed a PREVENT Annual Assurance Process. By now, you will have already completed the PREVENT Assurance Toolkit for your sector. The second phase of this assurance process is the completion of this PREVENT Annual Assurance Return.

The purpose of the initiative is to: illustrate what successful PREVENT delivery looks like; identify good working practice; proactively identify risk and areas for improvement; improve the quality of feedback to all sectors; and enable us to tailor our support throughout the year to sectors. We recognise the need to be thoughtful and considerate when conducting this work. Local barriers, resources, competing priorities and what constitutes as a proportionate response to risk are all important factors to consider when any assessments are conducted.

When completing this form, you will be asked to RAG rate your organisations level of compliance. Where your response is 'Green' please use the text box to detail examples of good working practices within your organisation. Where you select 'Amber' or 'Red' to the question, please use the text box to state any areas identified where additional focus may be required.

Examples of areas of good practice have also been highlighted in asterisks. These are areas which we believe would be beneficial for sectors to have in place but are not stipulated within the PREVENT Duty Guidance. Please use this area to detail any good working practices you have implemented within your organisation.

Senior sign off on this assurance statement is required for your organisation. This will confirm that this document provides an accurate assessment of compliance with PREVENT requirements for the financial year 2022/23.

Please note, return date for this form is 19th June 2023.

If you have any questions regarding this form, please email catherine.anderson@gov.scot

	GREEN	AMBER	RED	COMMENTS
Key area of Focus 1- Leadership				
1) There is active engagement from the Chief Executive and corporate senior management team with the range of PREVENT partners including Police.			x	The Director portfolios have recently changed, and a meeting is being arranged with relevant staff to discuss PREVENT.
2) A PREVENT Single Point of Contact (SPOC) has been appointed for the Health Board. This lead understands what is entailed in and has capacity to perform this role, and SVT have been provided with their name and contact details.			x	The PREVENT lead/SPOC for NHSB has recently retired. The meeting above will re visit and agree governance structure/roles and responsibility within NHSB going forward. Interim information Re SPOC available on NHSB PREVENT intranet page. Once roles decided, works will commence to ensure a greater awareness of role of SPOC across services (link to training).
3) Health Boards' arrangements for delivering PREVENT effectively link into those in place for child and adult protection. Chief Executives liaise with their Local Authority counterparts and advise Chief Officers of the local Health and Social Care Partnerships how to discharge the duty on their behalf and to report on performance.		x		Established processes in place. Chief Executive/New Director arrangements to be confirmed. There is information on NHSB intranet and within procedures regarding how to escalate CP/ASP concerns within NHSB and when concerns need to be raised with external agencies.

				There is a specific PREVENT NHSB intranet page, this will need refreshing by the new Director. PREVENT responsibilities are linked to into those in place for Child and Adult Protection although there are opportunities to further develop this. PREVENT Guidance and procedures are in place, which are complied with, re CP and ASP adults and available on the intranet.
4) In view of their responsibilities for prison healthcare services, it is expected that the Health Board Chief Executives will inform prison governors of their PREVENT plans and fully engage prison healthcare staff in relevant training and development activities.	x			Not applicable NHSB does not have any prisons within the region.
5) A strategic sector lead for your sector is an active member of the PREVENT sub-group. The health SPOC is aware of who this strategic sector lead is and engages with them as necessary in the first instance for advice or guidance on any PREVENT related concerns and provides relevant updates to be fed into the Sub-Group by the strategic sector lead on their behalf.	x			NHSB has representation at - East Region CONTEST meeting - PREVENT SPOC Network
6) *Additional good practice* Is the SPOC engaged with networks as a means of obtaining support for PREVENT delivery? Eg SPOC network, signed up to Knowledge Hub.	x			Current NHSB SPOC attends Health SPOC network
Key Area of Focus 2- Training				
1) Where there are signs that someone has been or is being drawn into terrorism, NHS staff are trained to recognise those signs correctly and are aware of and can locate available support, including making a referral, when necessary via their Health Boards PREVENT SPOC. The Health SPOC ensures that all relevant (frontline and non-frontline) staff are aware of their duty with regard to PREVENT.		x		Currently all NHSB staff complete a Public Protection e-learning module which includes information about PREVENT and links to UK Home Office training. The current training arrangement does not allow NHSB to capture how many staff complete the UK Home Office training.

				Going forward assurance is required that staff members are receiving the appropriate level of PREVENT training and are confident in identifying suspected signs of radicalisation. Proposal to be presented to NHSB Training & Education Board, for UK Home Office training module to be added to internal e-learning platform. This will facilitate tracking of staff completing the training. As well as ensuring that all NHSB staff have access to relevant PREVENT awareness training commensurate to their role and responsibility. Alongside this a training implementation plan will be developed that details which staff need to be trained on PREVENT.
2) *Additional good practice* Have you developed a training plan detailing what staff need to be trained on PREVENT and are linked into ongoing training/refresher opportunities for training for new and existing staff?			x	As above
Key Area of Focus 3- Referrals				
1) Where there are signs that someone has been, or is being drawn into terrorism, NHS staff are aware of the referral process within the health board and know to make a referral via their Health Board PREVENT SPOC.		x		There is information available to staff on the intranet PREVENT and ASP/CP pages. There is a need to revisit staff awareness/knowledge of roles and responsibilities.

2) *Additional good practice* Does your health board have the PREVENT SPOC's name and details and referral form on the organisations internal staff system? Are staff aware that it is there and know how to complete it?		x		Information on Intranet. Need assurance that staff aware and know how to complete it
Key Area of Focus 4- Information Sharing				
1) Staff understand how to balance patient confidentiality with the PREVENT duty. They know from whom they can get advice and support on confidentiality issues when responding to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment. There are procedures both internally and externally for sharing information about vulnerable individuals (where appropriate to do so) in line with the Counter Terrorism Security Act 2015 which should be used as the basis of information sharing. This includes information sharing agreements where possible and/or deemed necessary.	x			PREVENT Multi agency information agreements in place, for reporting concerns and information sharing in line with Child and Adult Support and Protection.
Key Area of Focus 5- Partnership				
1) The Health Board demonstrates that they are engaged with a local Multi-Agency group and additional PREVENT groups where appropriate, to agree and coordinate PREVENT activity based on a shared understanding of the threat, risk and vulnerability in the area.	x			NHSB has representation on various groups
2) The Health Board has a PREVENT Action Plan agreed and in place with the actions reflected in the implementation plan. The action plan makes reference to existing policies, procedures and protocols.			x	Draft Policy in place awaiting approval by new Director before commences consultation period.
3) There are mechanisms for exception reporting to the PREVENT sub-group and for performance reporting to the NHS Scotland Chief Operating Officer who will represent NHS Scotland on the Strategic Contest Board for Scotland (SCBS).			x	An agreed process to be developed and added as an appendix to the policy
Key Area of Focus 6- Monitoring				
1) The Health Board has put appropriate arrangements in place to monitor the delivery and performance of their PREVENT Action Plan and any impact on other duties.			x	As above
Key Area of Focus 7- Commissioning and Procurement				
1) The PREVENT Duty is covered in contracts and grants made with and to any organisation (including private and voluntary agencies) performing a relevant function on the Health Board's behalf. The health boards procurement team are aware of their responsibilities under the PREVENT Duty.			x	Await instruction from new Director

Key Area of Focus 8- PMAP				
1) The Health Board is 'PMAP ready' in the instance that a PMAP panel is established and their membership at that panel is required. The health SPOC is aware of who their local authority PREVENT SPOC and PMAP chair is.	x			Key staff have attended PMAP training. Multi-agency links in place.

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Chief Executive: NHS Borders

Minutes of a meeting of the **Scottish Borders Health & Social Care Strategic Planning Group** held on **Wednesday 6 December 2023** at **10am – 12pm** via Microsoft Teams

Present:

Cllr David Parker (Chair)
Chris Myers, Chief Officer for Health & Social Care
Caroline Green, Public Member
Lynn Gallacher, Borders Carer Centre
Sohail Bhatti, Director of Public Health
David Bell, Staff Officer
Kathleen Travers, Borders Care Voice
Linda Jackson, Service User Representative
Vicki MacPherson, Mental Health and Learning Disability Services
Wendy Henderson, Independent Sector Lead

In Attendance: John Barrow, Bhav Joshi, Elaine Dickson, Janet Bennison, Katrina Culley, Claire Oliver, Amanda Young (Minute Taker)

1. APOLOGIES AND ANNOUCMENTS

1.1. Apologies received from: Gwyneth Lennox, Colin McGrath

2. MINUTES OF THE PREVIOUS MEETING

2.1. Linda Jackson asked that the minutes be approved with adjustment to Item 12: AOB Winter preparedness, adding the words ‘in relation to carers involvement’.

2.2. **Scottish Borders Health & Social Care Strategic Planning Group** approved the Minute of the previous meeting held 1 November 2023 with the changes agreed.

3. MATTERS ARISING/ACTION TRACKER

3.1. Action Tracker was discussed:

3.2. Action 13 Complete

3.3. Wendy Henderson provided an update on Action 14 and will bring updates to future meetings

The **Scottish Borders Health & Social Care Strategic Planning Group** noted the Action Tracker.

4. **Scottish Borders Macmillan Improving Cancer Journeys**

4.1. Wendy Henderson discussed the Improving Cancer Journey paper saying that Stage 1 impact assessment had been through a very robust impact assessment. Wendy is encouraged by the level of understanding, embedded throughout, and noted that praise should be given where praise is due and this paper is an exemplar of best practice in addressing Inequalities on the Improving Cancer Journey.

4.2. Chris Myers gave an overview of the Improving Cancer Journey paper on behalf of Jen Holland explaining it was part of a MacMillan funded national programme and highlighting key points discussed. Funding and support has previously often been focused on acute care and clinical care. Improving Cancer Journeys is about addressing the social needs of people living with cancer and helping people to live better in the community. This is considered an important development as figures projected today suggest that the number of people living with cancer in the Borders is set to increase to around a 1000 a year by 2025.

4.3. Linda Jackson asked about what happens at the end of the journey with the Link Worker, and if there were plans for a leaflet to be developed and requested that any future production be written in plain English, with less acronyms.

4.4. The link worker model would operate, providing support and developing links across communities. People will be able to follow various pathways, and move both back and across pathways as needed.

4.5. Kathleen Travers commented on communications to the public asking for less jargon and less acronyms. Kathleen asked about the Local Area Coordination Review and if this would have any impact on this proposal.

4.6. Chris Myers stated there was no expected impact and the Local Area Coordination Review paper is due to come to a future SPG meeting. The review was essentially to do stocktake of the service, to look at the alignment to our strategic approach, to assess best practice hope to see further development of the Local Area Coordination services. An independent review report had recently been returned for an officer's response. Staff are aware of the findings of the review but recommendations have yet to be shared as decisions on what recommendations are to be accepted have not happened yet. This is ongoing and we should see a real synergy with Local Area Coordination service and not create a silo in the Borders service provision.

4.7. Wendy Henderson welcomed the papers, and the proposal, noting the support socially and financially for families as an outcome. In terms of equality, Wendy asked if the number of acronyms contained in the paper could be addressed before publication.

4.8. Caroline Green complimented the Macmillan Cancer Centre, noting the support, the ability to liaise with other centres and help with any problems presented, and if they have the opportunity to do more of this, this is even better.

4.9. Cllr Parker thanked Caroline for her contribution, agreeing that this was good to hear.

Scottish Borders Health & Social Care Strategic Planning Group approved the Improving Cancer Journey with changes to the acronyms and jargon as discussed before publication.

5. **Carer's Strategy and Implementation Plan**

5.1. John Barrow gave an overview of the paper discussing how the strategy has evolved, recognising that only by getting the needs of those being cared for, will those providing care have their needs met. John then discussed the Carer's Workstream meetings, the purpose of these meetings, and how this has created a platform for carers voices to be heard. Furthermore, work is ongoing to consult with different communities about the support needed, recognising that different areas have different needs and that a one size fits all strategy will not work. Carers respite needs are also being addressed through the strategy.

5.2. Chris Myers thanked John Barrow and the Carers Workstream, Linda Jackson, Lynn Gallacher and other partners for the work in this area. It is a hugely important piece of work and one of the strategic objectives of the HSCP. The document states the intent of where we want to go and contains clear actions and is a very important document and a key moment in time for the IJB.

5.3. Lynn Gallacher confirmed that the work involved in the paper has been very much a partnership approach. Carers are at the heart of what we do, and looking to the future, that we evolve and fully engage with carers to provide support for carers.

5.4. Wendy Henderson thanked John Barrow for pulling the paper together and recognised the evidence of great partnership working and shared working. Wendy stated she will be running a workshop for the sub-group of the Carers Workstream to help identify inequalities in care and support for both carer and cared for. Wendy then discussed changing legislation in relation to Young Carers and the ways that children have 'lived experience' of care and the challenges around adult care service and how this links to Young Carers.

5.5. Further discussion followed in terms of the approach between adult carers and young carers and the delegated responsibilities. In the Borders, the IJB does not have Young Carers services delegated to it. However, Carers funding is essentially 'ageless' as a result a proportion of national funding for carers that is passed to the IJB is earmarked and passed onto Children's Services. John Barrow and Scott Watson are sighted on this and there is a targeted approach ongoing towards supporting Young Carers.

5.6. Linda Jackson would like to see more acknowledgment of the Borders Carers Centre in the final paper, to draw attention to the work the Borders Carers Centre does on behalf of the Council through the commissioning services.

5.7. Chris Myers noted this was a key point. It is important that key partners and those who work in partnership need to be recognised in the final version. Consideration should be given to joint branding too.

5.8. There followed a discussion about support for Carers who are no longer caring for person, for example when someone has been admitted to a care home. It was noted that legislation requires Carers' Plans to be in place, and that there are support groups, in person, online and telephone based. These should all be signposted to the care giver through their plan and interactions with social work. Care Homes also look out for those who have previously provided care, acknowledging the sense of loss when a person is moved from the family home and are aware it may be sometime later when the impact is felt by the person who previously provided the care.

Scottish Borders Health & Social Care Strategic Planning Group approved the Carers Strategy and Implementation Plan with the changes discussed.

6. **Tackling Healthcare Inequalities Strategy**

6.1. Sohail Bhatti noted the presentation has been shared and discussed the index of multiple depravation and the impact of that on data, explaining how the system averages out figures based on areas, which can result in hidden depravation. Data shared demonstrates the need to tackle health care inequalities by looking at the causes. Causes discussed included poverty, wage rates, public transport infrastructure, alcohol and drug abuse, and domestic violence. It was noted that partnership working is very important and this is a significant piece of work that connects strongly to our strategic aims.

6.2. David Bell thanked Sohail and noted that the facts were not a surprise and asked if the data could this be broken down further, enquiring about areas away from the hospital experiencing more inequalities than the central area of the borders and added that this could be a great driver for both SBC and NHSB to recognise that remote areas are impacted by the distance between towns and the BGH and that providing more community based services may reduce inequalities experienced in remote rural areas.

6.3. Wendy Henderson welcomed the report and asked in terms of membership of the group working on the paper, is there a place for the Human Rights and Inequalities Lead and offered to help with this piece of work.

6.4. Sohail Bhatti agreed and welcomed Wendy's comments and noted the differences between health inequalities and equality work and need to educate on this point.

6.5. Chris Myers explained that a result of the IJB development session with the improvement service around priorities and self-assessment and discussion with IJB members, there needs to be a focus on reducing poverty and inequalities and on early intervention and prevention. As a result, there is work going on in the background to bring communities, staff and partners together. Sohail Bhatti's team is involved as is Claire Oliver's team looking at engagement and alignment with the area partnerships

in the Scottish Borders, to develop a function that brings value and support the reduction in health care inequalities.

Scottish Borders Health & Social Care Strategic Planning Group noted the Tackling Healthcare Inequalities Strategy paper and looks forward to updates in the future.

7. **Financial Planning Principles**

7.1. Chris Myers presented a PowerPoint discussing financial planning principles for the IJB, both in terms of process, and legislative requirements, covering the challenges, opportunities and risks. Mr Myers explained that by following guidance included in the legislation, a letter will be issued requesting payment for the IJB services and explained proposed changes in how budgets are set, reflecting that there are significant budget pressures all around. It was noted the financial planning need to focus on financial sustainability and must align to the strategic aims of the group. He would use the views of the group and the IJB to inform the final letter drafted to the Directors of Finance in the Scottish Borders Council and NHS Borders.

7.2. Lynn Gallagher asked about where the Carers Act funding sits. Mr Myers explained that it sits under the IJB but SBC administer this funding in line with the Direction from the IJB on budgets. Carers Act Funding has been looked at closely and a previous underspend was carried forward, but that we are likely to overspend this year on the carers budget. Mr Myers noted that in addition the IJB are investing in carers and the cared for, from other areas/budgets, not only from Carers Act Funding.

7.3. The Strategic Planning Group discussed issues around financial planning for the IJB noting there needs to be a focus on prevention and early intervention and need to align all financial planning with its strategic aims. The need for robust inequality assessments, population expectations, workforce challenges, the pressures on budgets both local and national, Time for Change conversations taking place currently in communities, and what the future may look like were all considered.

7.4. The group acknowledged that there will be more changes and difficult decisions to be made as financial pressures will become the new normal. Cllr Parker thanked Mr Myers for bringing the principles and stated the group would look forward to see how this evolves.

Scottish Borders Health & Social Care Strategic Planning Group noted the **Financial Planning Principles** presentation and looks forward to updates in the future.

8. **Emergency Department Review**

8.1. Bhav Joshi introduced Dr Janet Bennison, Associate Medical Director and Elaine Dickson, Associate Director of Nursing and then discussed Emergency Department Workforce Review.

8.2. Mr Joshi discussed the review, explaining that the review looked at the safe provision of staffing risks currently being carried in the Emergency Department at NHSB, noting there is little appetite, nationally for the ED to be operational in an any form less than or equal to the current status quo. Mr Joshi the talked through the slides covering actions previously taken, the risks around the current staffing model, the risks currently listed on the risk register, the longer term ambitions, the governance and process and that recommendations contained in the review have been measured against benchmarking criteria. Mr Joshi underlined that the Emergency Department Review, although improves and reduces the current risk level, it does not aim to remove all risks and the costs involved are the bare minimum to bring the current risk level to a more palatable level of risk. Five proposals were presented to Strategic Planning Group which included an ask for £1.1m.

8.3. Cllr Parker asked how are the proposals are to be paid for, observing that the Health Board has a substantial deficit, and noted that a financial plan would need to come with the ask within the paper, once it gets to the IJB.

8.4. Mr Myers thanked Mr Joshi for presenting the paper and discussed possible streams of funding that could be accessed and whether this we could come from a 'set aside' fund and/or from de-prioritisation of another service and that the paper has come to SPG under planning processes of the IJB, rather than with an operational oversight and that these proposals will go before the Health Board (for funding decisions) on Thursday and the IJB once the financial plan was clear.

8.5. There followed a discussion about the future of the Emergency Department. Key points mentioned were: funding is reducing overall, the need for an Emergency Department in the Borders, changes in the operation of the Emergency Department, moving funding from other services and/or de-prioritisation of other services, the current operational risks, the risks of not acting, reputational risks, adverse events, and risks to staff themselves, including increased sickness absence and pressured working environments. There was further discussion on ways to reduce Emergency Department presentations, trends in the nature of what brings people to the Emergency Department and new legislation relating to safe staffing were also considered.

8.6. The Strategic Planning Group acknowledged that the people of the Borders expect a good emergency service, noting that the Emergency Department is often seen as the front face of the NHS. Bhav Joshi noted that the proposals brought today are not to make an 'all singing and dancing' Emergency Department, but are bring it to a bare minimum, *safer* operational department, being mindful that the 'Safe Staffing' legislation is imminent.

8.7. Cllr Parker observed that the paper in its present form is saying that the emergency Department must have this additional funding but does not reflect where this funding is to come from, particularly when there is significant debt currently. The concerns need to be addressed but the articulation of the funding plans need to be improved before the paper comes to the IJB for approval.

8.8. Mr Myers recognised the risks involved, noting that the Emergency Department Review paper is due to go to the next Health Board meeting and funding mechanism would be discussed in more detail at that point, therefore by the time it reaches the IJB, there will be a stronger financial plan in place.

Scottish Borders Health & Social Care Strategic Planning Group noted the Emergency Department Review presentation.

9. **Any Other Business**
   No further business raised

10. **Date of next meeting**
    Wednesday 7 February 2024, 10am -12pm

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Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 March 2024

STRATEGIC PLANNING GROUP MINUTES

Report by Iris Bishop, Board Secretary

1. PURPOSE AND SUMMARY

1.1. To provide the Integration Joint Board with the approved minutes of the Strategic Planning Group meeting, as an update on key actions and issues arising from the meeting held on 6 December 2023.

1.2 The meeting had focused on: Carer's Strategy and Implementation Plan; Scottish Borders Macmillan Improving Cancer Journeys; Tackling Healthcare Inequalities Strategy; and Emergency Department Review

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) Note the SPG minutes of 6 December 2023.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

3.2. All items discussed at the SPG will fall into the categories listed below.

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
x	x	x	x	x	x

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x	x	x	x	x	x

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required.

5. BACKGROUND

5.1. Once approved minutes from the Strategic Planning Group and Integration Joint Board Audit Committee are submitted to the Integration Joint Board for noting.

6. IMPACTS

Community Health and Wellbeing Outcomes

6.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	N
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	N
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	N
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	N
5	Health and social care services contribute to reducing health inequalities.	N
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	N
7	People who use health and social care services are safe from harm.	N
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	N
9	Resources are used effectively and efficiently in the provision of health and social care services.	N

Financial impacts

6.2. There are no costs attached to any of the recommendations contained in this report.

Equality, Human Rights and Fairer Scotland Duty

6.3. An IIA is not required.

Legislative considerations

6.4. Not applicable.

Climate Change and Sustainability

6.5. Not applicable.

Risk and Mitigations

6.6. Not applicable.

7. CONSULTATION

Communities consulted

7.1. Not applicable.

Integration Joint Board Officers consulted

7.2. The IJB Board Secretary and the IJB Chief Officer have been consulted.

Approved by:

Chris Myers, Chief Officer Health & Social Care

Author(s)

Iris Bishop, Board Secretary

Background Papers: SPG Minutes 06.12.23

Previous Minute Reference: Not applicable

For more information on this report, contact us at Iris Bishop, Board Secretary, email: iris.bishop@borders.scot.nhs.uk

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