

Borders NHS Board



Meeting Date: 27 June 2019

Approved by:	Dr Cliff Sharp, Medical Director
Author:	Elaine Cockburn, Head of Clinical Governance & Quality
CLINICAL GOVERNANCE & QUALITY UPDATE JUNE 2019	
Purpose of Report:	
<p>The purpose of this report is to provide the NHS Borders Board with an overview of activities and progress across areas of:-</p> <ul style="list-style-type: none"> • Patient safety • Clinical effectiveness • Person centred health and care • Research Governance 	
Recommendations:	
The Board is asked to note this report.	
Approval Pathways:	
This report has been reviewed by the Board Executive Team.	
Executive Summary:	
<p>This report highlights the following areas of the CG&Q portfolio:-</p> <ul style="list-style-type: none"> • Patient safety <ul style="list-style-type: none"> ○ Scottish patient safety (SPSP) workstreams ○ Adverse events ○ Duty of candour (DoC) ○ Hospital standardised mortality ratios (HSMR) quarterly publication update • Clinical effectiveness <ul style="list-style-type: none"> ○ Data and quality improvement (QI) • Person-centred health and care <ul style="list-style-type: none"> ○ Feedback and complaints including key performance indicators (KPIs) ○ General Practice complaints ○ Scottish public services ombudsman (SPSO) ○ Volunteering • Research Governance <ul style="list-style-type: none"> ○ Recruitment update ○ Chief scientist office (CSO) annual review 	
Impact of item/issues on:	
Strategic Context	The NHS Scotland Healthcare Strategy (2010) and NHS

	Borders Corporate Objectives guide this report
Patient Safety/Clinical Impact	Patient safety, person-centred care and quality improvement sit within the Clinical Governance & Quality portfolio
Staffing/Workforce	Service and activities are provided within agreed resources and staffing parameters
Finance/Resources	None
Risk Implications	In compliance as required
Equality and Diversity	Complaint
Consultation	The content of this paper is reported to Clinical Boards, Clinical Governance Groups, the Clinical Executive Operational Group and to the Board Clinical and Public Governance Committees
Glossary	CG&Q – Clinical Governance & Quality SPSP -Scottish Patient Safety Programme HSMR – Hospital Standardised Mortality Ratios MKU – Margaret Kerr Unit CAUTI – Catheter Associated Urinary Tract Infection NEWS – National Early Warning Score MCQIC – Maternity & Children Quality Improvement Collaborative DoC – Duty of Candour KPI – Key Performance Indicator HIS – Healthcare Improvement Scotland R&D – Research and Development CSO – Chief Scientist Office SPSO – Scottish Public Services Ombudsman PMO – Programme Management Office QI – Quality Improvement

PATIENT SAFETY

The Scottish Patient Safety Programme (SPSP), part of Healthcare Improvement Scotland's ihub, is a unique national initiative that aims to improve the safety and reliability of healthcare and reduce harm, whenever care is delivered. From an initial focus on acute hospitals, work now includes safety improvement programmes for Acute Adult, Primary Care, Maternity and Children, Medicines and Mental Health.

The Acute Adult programme supports boards to work on reducing harm from:

- Deterioration, including Sepsis and Acute Kidney Injury
- Falls
- Pressure Ulcers
- Catheter Associated Urinary Tract Infection (CAUTI).

Deteriorating Patients

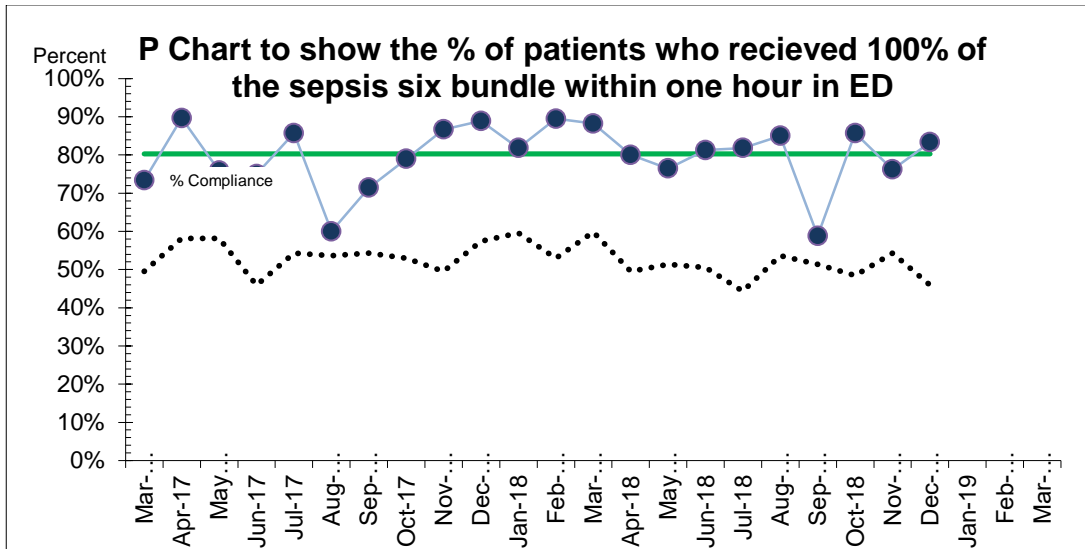
SPSP Aim: To reduce mortality and harm for people in acute hospitals by reliable recognition and response to acutely unwell patients. Outcome Measures:

- HSMR
- Sepsis
- Mortality Rate
- Cardiac Arrest Rate

Workstream 1: Sepsis

Our Aim: Targeting 100% of sepsis patients getting sepsis 6 within 1hr of identification in the Emergency Department (ED)

Data for the period after October 2018 is still to be added to the P Chart below as there have been delays in the collection and analysis of data due to resource and skill issues.

**Progress:**

Explore reasoning for why sepsis 6 is missed and identifying patterns of failure

Tests of Change:

- Liaised with the Scottish Ambulance Service (SAS) regarding receiving patients who have been given intravenous (IV) antibiotics en-route.
- Organised process for this but nil attends as yet.

Plan for next steps:

- As above – liaise with the Medical Assessment Unit (ward 6) and support the surgical assessment units in embedding sepsis care in line with the ED process.
- Be part of the pre-hospital drive to give antibiotics appropriately in the primary care settings for prolonged transfers to hospital.

Workstream 2: National Early Warning Scores (NEWS)**Our Aims:**

1. To introduce a system of evidence-based and reliable early recognition of the deteriorating patient in the community settings (Scottish Borders Care Homes & Mental Health wards)
2. To develop a safe and effective escalation protocol in response to early detection of the deteriorating patient
3. To implement the regular monitoring of patients' clinical observations and the use of National Early warning Score (NEWS) /sepsis screening tools in the community settings as described above in line with SIGN guidelines (SIGN 2014)
4. To develop and implement a structured, community specific approach to the assessment of un-well patients using the NEWS and sepsis screening tools.

A key area of focus was Identifying baseline clinical observation figures for each individual in the Care Home setting to work from pre-deterioration to ensure the correct escalation pathway is followed. This was due to the majority of Care Home patients already having a high NEWS score as a normal state.

Progress:

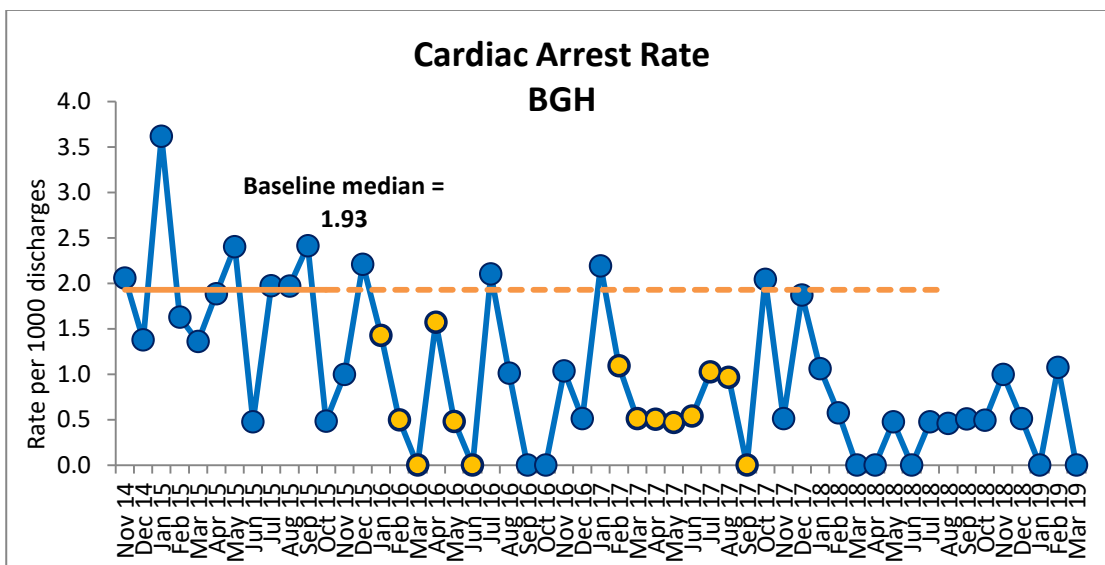
This project is now complete and was implemented between October 2017 – November 2018. NEWS scores have supported decision making and aided structured communication in relation to the recognition of deteriorating clinical conditions. This has enabled better communication between residents/patients, families, GPs and the Borders Emergency Care Centre (BECS) to prevent unnecessary intervention or transfers to hospital.

Healthcare Improvement Scotland (HIS) Update on National Early Warning Score (NEWS) 2:

In February 2018 all boards were sent a position statement to outline the revision of the National Early Warning Score (NEWS 2) and the impact on approach to deteriorating patients and sepsis. There is now a learning module called ‘National Early Warning Score (NEWS) in NHS Scotland’ which is now available on TURAS. NEWS 2 lanyard cards are also now available and can be ordered through HIS.

Workstream 3: Cardiac Arrest

Cardiac arrest rates for Borders General Hospital (BGH) shows a positive picture and one which will be continually monitored.



Comments:

There is an issue with non compliance of the completion of the Resuscitation Record Form as so far in 2019, despite there having been thirty five 2222 calls made through the switchboard, only two forms have been completed and sent to the Resuscitation Officer.

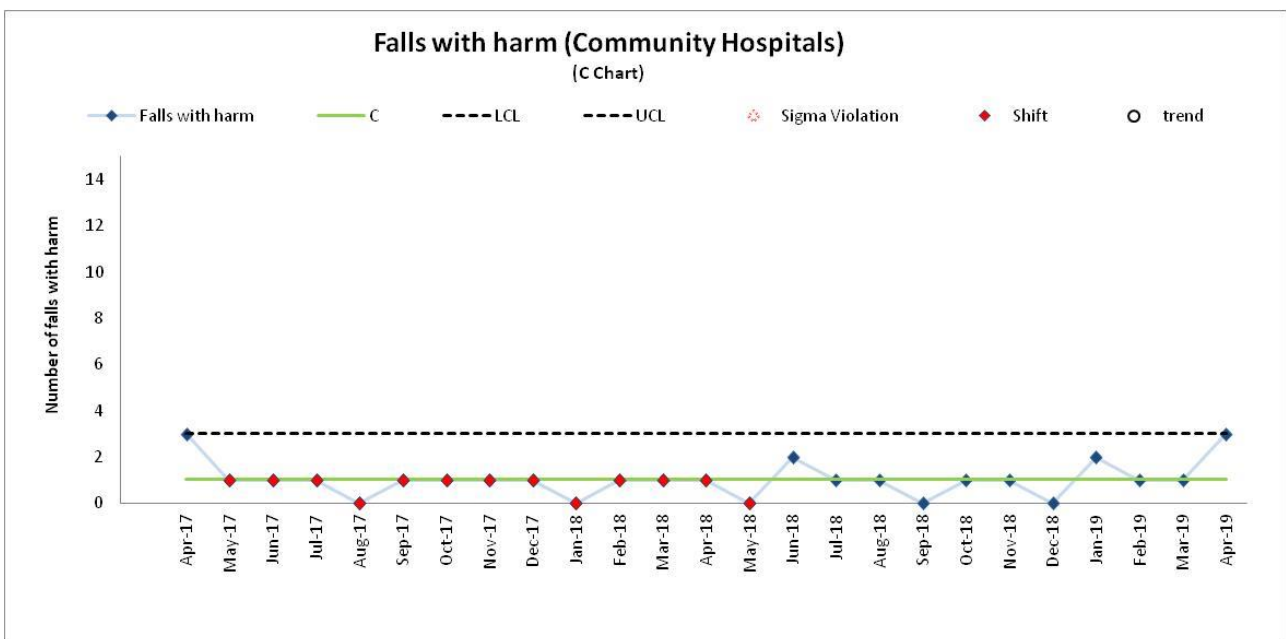
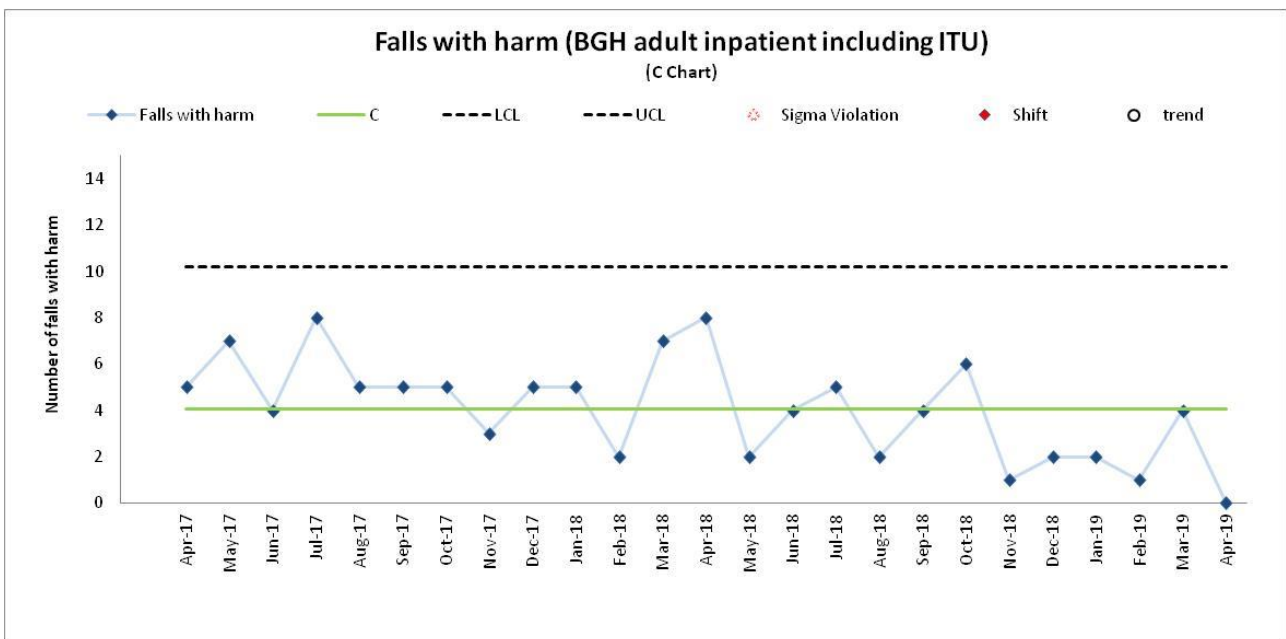
Improvement work has commenced involving the Resuscitation Officer and Clinical Governance & Quality Team to improve organisational compliance of the completion of the forms so that any areas of learning and improvement can be identified and acted upon.

FALLS

Work to reduce the prevalence of all falls/slips/trips across all NHS borders inpatient areas is being undertaken through a number of workstreams. These include:

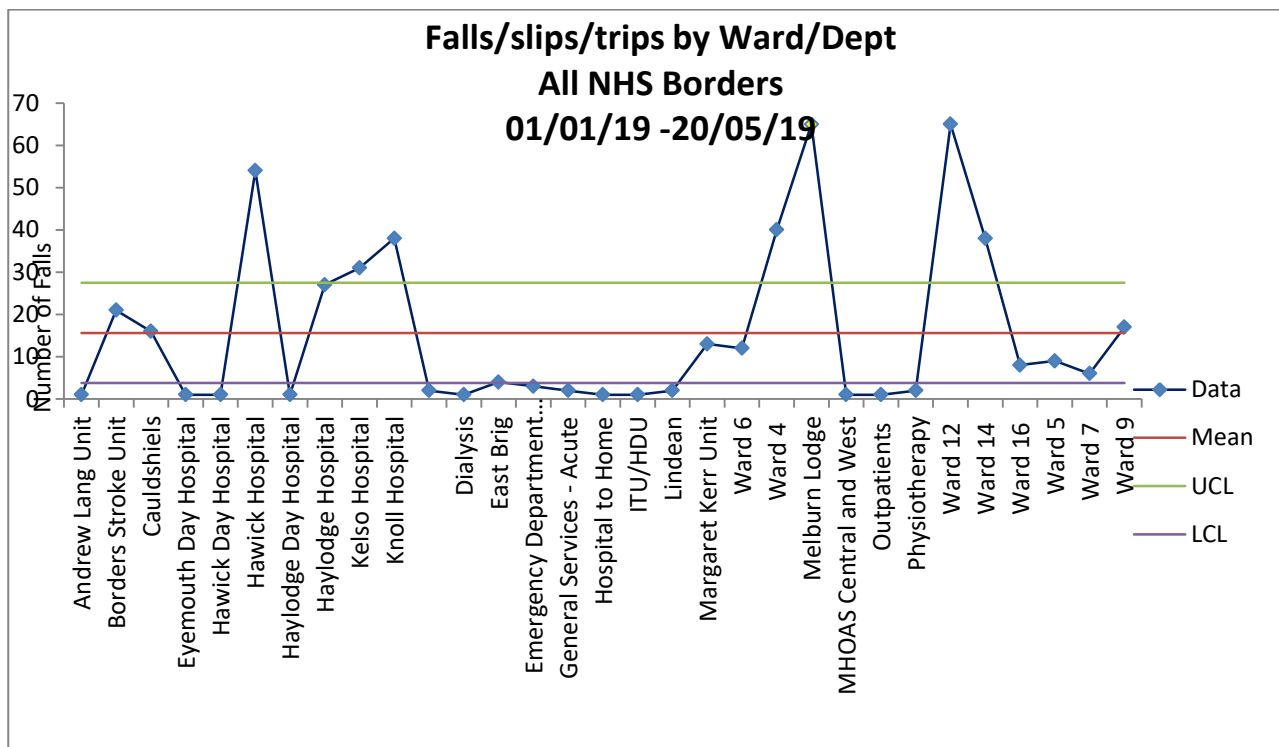
- Back to Basics, Forward to Excellence Programme
- Excellence in Care
- Involvement from Quality Improvement Facilitators
- Numerous Quality Improvement projects undertaken by staff across the organisation
- Educational initiatives including toolbox talks.
- Review of the Person Centred Falls Bundle

The rate of falls across NHS Borders is increasing however the number of falls resulting in harm to the patient have significantly reduced since October 2018.



This year to date, the areas across NHS Borders where the highest number of patient related falls occurred are:

- Hawick Community Hospital
- Melburn Lodge
- Ward 12



PRESSURE ULCERS

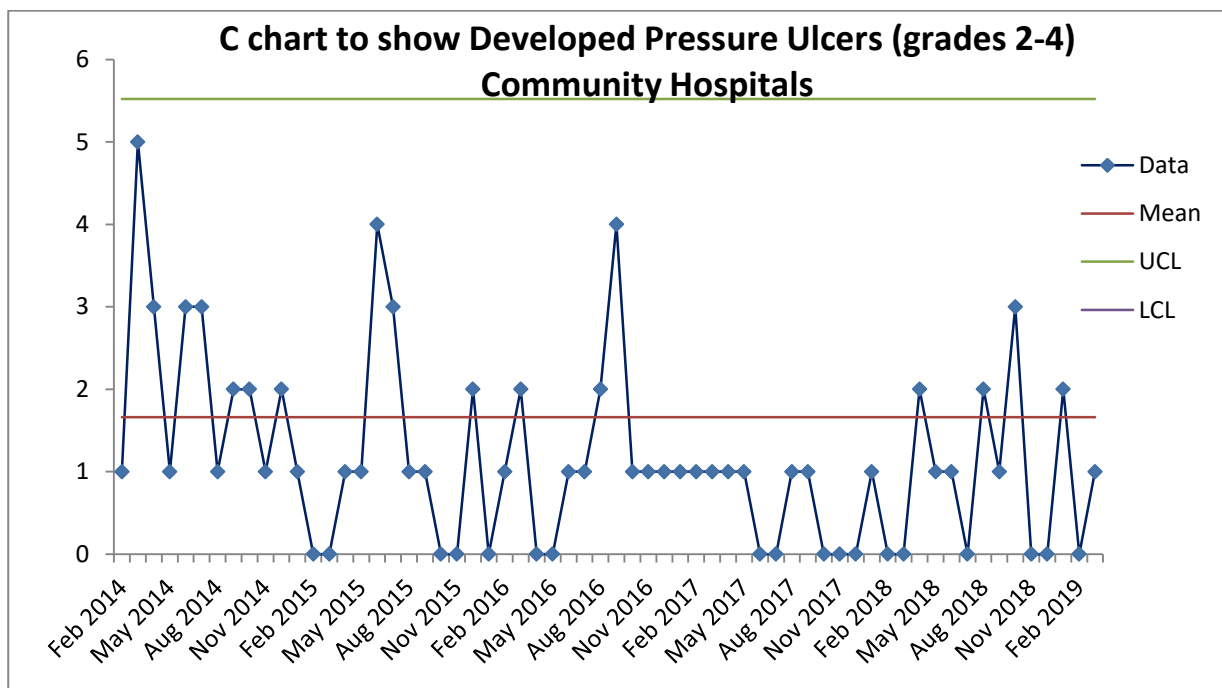
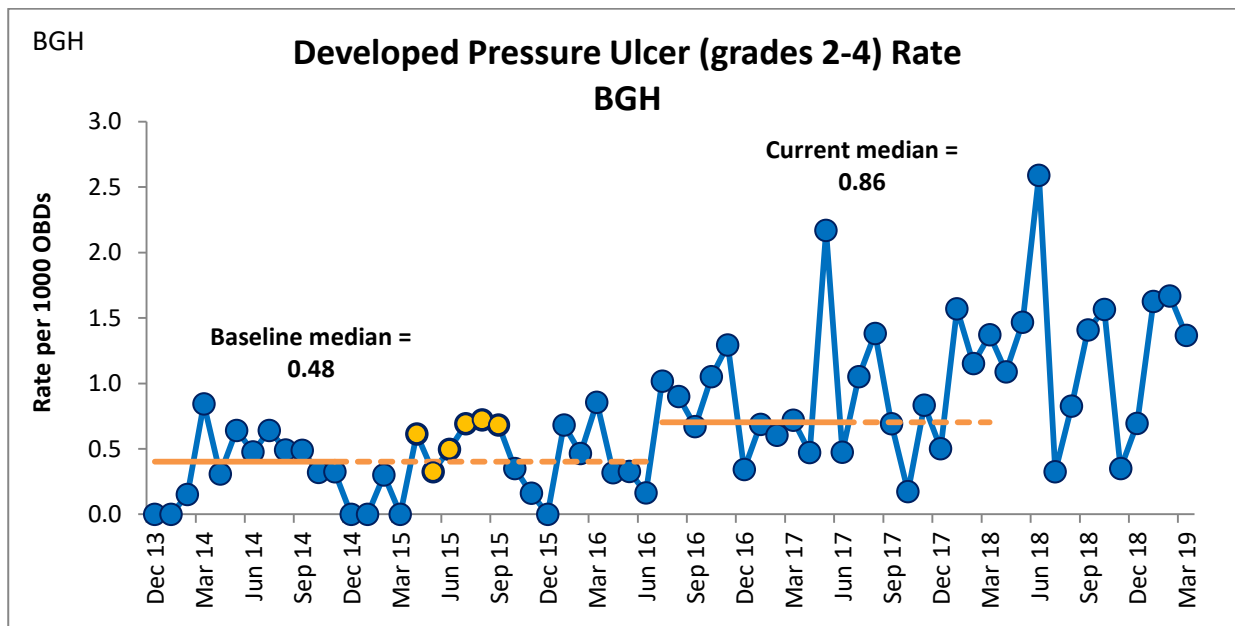
Progress:

The ZERO HERO concept was launched on the 14 and 15 of October 2018 in conjunction with world "Stop the Pressure" day. This included a study day for hospital and community staff covering prevention, grading and treatment of pressure ulcers. We raised the profile of pressure ulcer prevention through this initiative and engaged staff in our aim to achieve zero developed pressure ulcers.

Offloading heel wedges have been successfully used in one ward who achieved over 100 days without a heel pressure injury and we are encouraging all areas to order this equipment.

- There have been two Pressure Ulcer Collaborative days with good attendance and positive feedback.
- Link Nurse criteria has been formalised and the concept of link HCSW's has been launched, with every area identifying a link HCSW and monthly meetings to take place.
- A new Wound Formulary and Dressing Selection Guide have been launched so that staff have clear guidance on dressing selections for common wounds.
- Withdrawal of the use of Sudocrem and the introduction of appropriate barrier cream and spray with education

Currently our data is not validated, we plan to do a snapshot of time were all DATIX are validated by the tissue viability nurse to ensure our data is an accurate reflection of prevalence.



Both Hawick & Haylodge Community Hospitals have not reported a developed pressure damage event since January 2019. Kelso Community Hospital have reported zero incidents since January 2018.

CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Our Aim: Reduce catheter use by 10% in one elderly care ward (ward 12) by December 2019

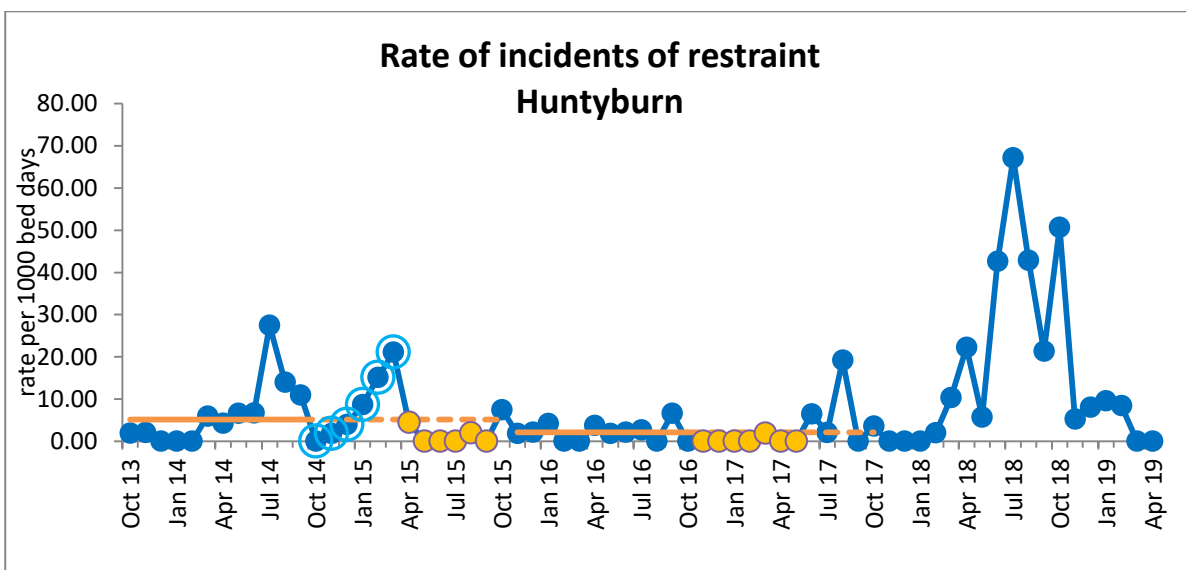
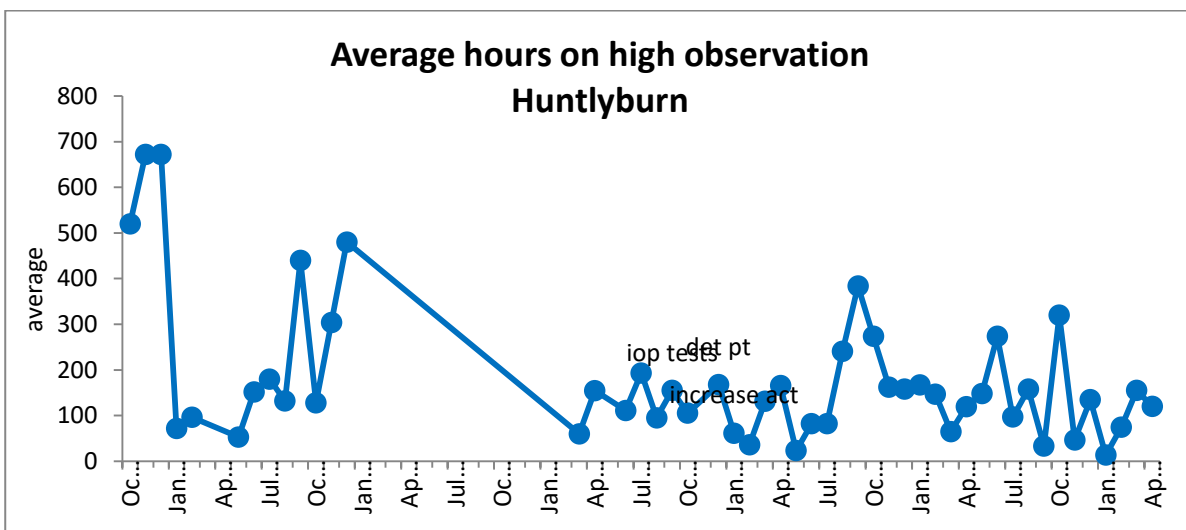
Progress:

- Clinical poster sent to all clinical areas to be displayed in the clinical room (non-patient areas)

- Urinary catheter passports audited monthly across all wards. Data discussed at CAUTI group and reported through existing SPSP routes
- Training resource identified to specifically follow up catheter passport audit and provide support and training to staff
- Urinary catheter policy reviewed and content reduced to ensure document is workable in practice
- Medical Consultant support identified to lead project in ward 12
- Senior Charge Nurse and Registered Nurse (RN) support from ward 12 identified
- E-learning data accessed for analysis at CAUTI group
- Clinical Governance & Quality Team engaged in CAUTI group

MENTAL HEALTH

The SPSP for Mental Health has a focus on the workstreams identified below, including NHS Borders Acute (Huntlyburn) being a pilot site for Improving Observation in Practice. Early work suggests high level of therapeutic activity benefits and early identification of risks. Outcome data continues to be collected on a monthly basis via the reporting template from the Brigs and Huntlyburn. Multiple PDSA's in progress include spread of the work to Cauldshiels.



MATERNITY & CHILDREN QUALITY IMPROVEMENT COLLABORATIVE (MCQIC)

In collaboration with other work streams (deteriorating patient and infection control) within NHS Borders, maternity champions from other health boards and the McQic team continues.

The reporting to SPSP was previously person dependant but is now moving towards a team approach to further embed the reporting of all measures.

We continue to focus on reducing stillbirth rate currently 43 days since our last stillbirth.

PRIMARY CARE

The national teams are currently scoping the future of the programme.

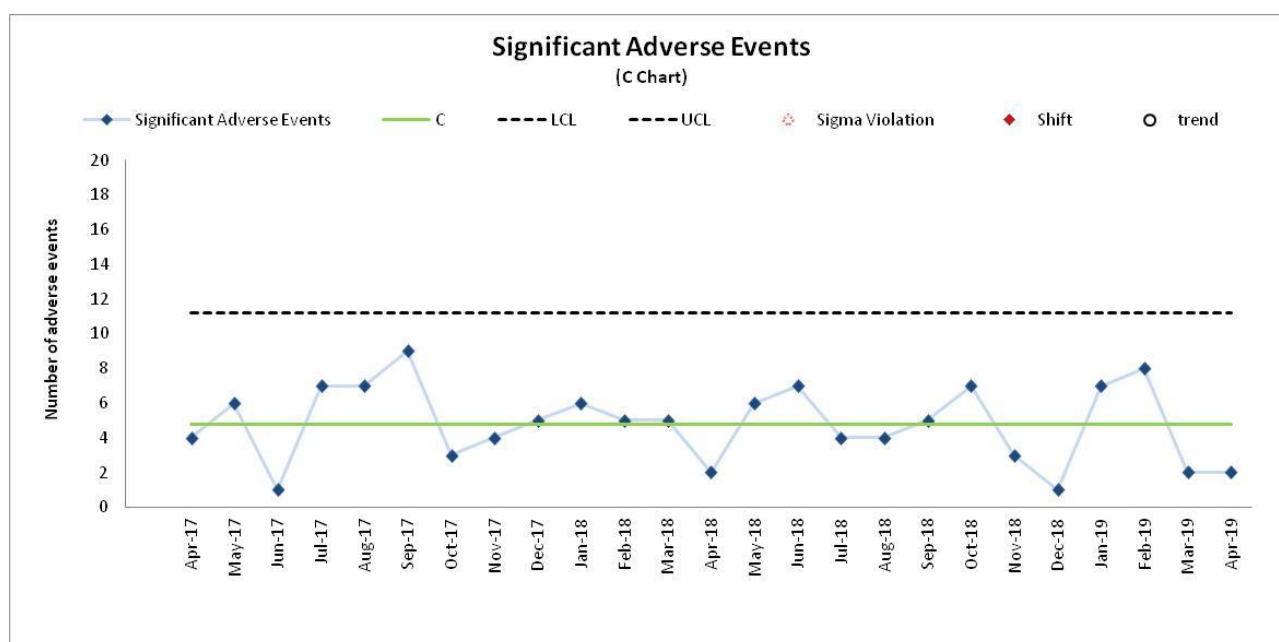
ADVERSE EVENT MANAGEMENT

NHS Borders continue to develop the process of reviewing adverse events in a timely manner, with a focus on identifying learning and driving improvements in practice. Currently a review of the Adverse Event Management Policy is underway led by the Patient Safety Team within Clinical Governance & Quality and the Risk & Safety Team. In addition, Significant Adverse Event Review (SAER) Guidelines are being written which will form the basis of a training programme for all colleagues on the list of potential lead reviewers.

There is also work planned to improve upon communication in relation to:

- Seeking feedback from patients and families following the completion of an SAER – through a questionnaire
- Seeking feedback from staff members who were involved in the SAER process – through a questionnaire
- How learning from SAERs is disseminated to staff across NHS Borders.

There is a sustained shift showing a decrease in the number of significant adverse events. There are a number of possible contributing factors including the reduction in falls with harm and Datix approvers being more responsive and downgrading adverse events more timely than previously.



Organisational Duty of Candour (DoC)

On 01 April 2018 the statutory Organisational Duty of Candour legislation came into force. The purpose of this new organisational duty of candour is to support the implementation of consistent responses across health and social care providers when there has been an unexpected event which has resulted in death or harm (as defined in the act). The requirements of this legislation are that people involved in an event understand what has happened, receive an apology and that the organisation learns from the events.

Recorded events

Between 01 April 2018 and 31 March 2019 there were four events which come under the organisational duty of candour. All of these were unintended events that resulted in harm as defined by the act. Details of the outcomes in relation to duty of candour are in the table below

Each event was reported on the electronic adverse event reporting system (Datix) and managed in accordance with the adverse event policy.

Type of unexpected or unintended event	Number of times this happened (01 April 2018 to 31 Mar 2019)
A person died	0
A person had their treatment increased	2
The structure of a person's body was changed	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	2
A person needing health treatment in order to prevent other injuries as listed above	0

Where a Significant Adverse Event Review (SAER) is carried out, this already fulfils all the criteria of the organisational duty of candour. This is the case for three of the identified events. For adverse events which do not prompt an SAER the adverse event reporting system itself has a section that is to be completed which should make practitioners think about duty of candour.

In all the cases referred to above NHS Borders Organisational Duty of Candour was fulfilled. The people affected were informed and received apologies on behalf of the organisation. In all cases appropriate levels of review were carried out to identify any opportunities for learning or putting preventative measures in place.

The area in which we do not perform so well is in the completion of the DoC section in the electronic adverse event reporting system. Staff are usually unsure whether an event comes under the DoC and often leave it blank. This highlights a need for further training and guidance when it comes to DoC. The adverse event management policy, processes and guidance are currently being updated to reflect NHS Borders' responsibility in relation to the DoC legislation. Once these reviews are complete a training plan will be put in place.

Other information.

This is the first year of duty of candour being in operation. It has been a year of learning which will continue as we reflect and refine our processes.

As required, NHS Borders will submit the report to Scottish Ministers and will also place it on the NHS Borders website and the intranet.

HOSPITAL STANDARDISED MORTALITY RATIOS (HSMR)

HSMRs published from August 2016 onwards cannot be compared to previous releases using a different baseline period. The current HSMR methodology was agreed in 2015/16. The purpose of that was to measure the change in mortality over time, and to enable acute hospitals to monitor their progress towards the Scottish Patient Safety Programme (SPSP) aim of reducing hospital mortality by a further 10% by December 2018. HSMR information for the period up to December 2018 was included in the May publication.

The end of this phase of the SPSP provides the opportunity to review the model methodology and subsequently update/ refine it. This ensures that the methodology continues to be robust and that comparisons which are made against the national average continue to be appropriate and relevant for each point in time.

National Summary

- The mean HSMR across Scotland for the Q3 October – December 2018 is 0.85 (provisional)
- NHS Dumfries & Galloway, our nearest comparator had a HSMR of 0.82 (provisional) in this quarter
- The mean HSMR across Scotland for the same period, Q3 October – December 2017 was 0.94

NHS Borders performance in Q3 2018 report

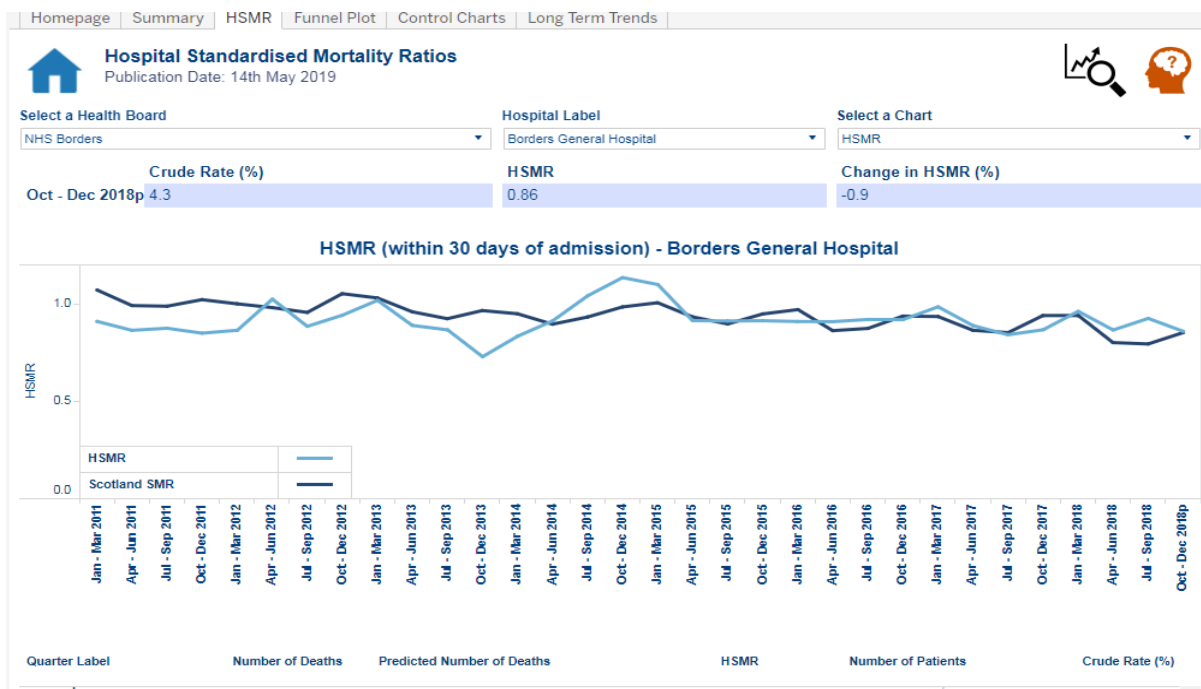
- NHS Borders HSMR for Q3 October – December 2018 is 0.86 (provisional)

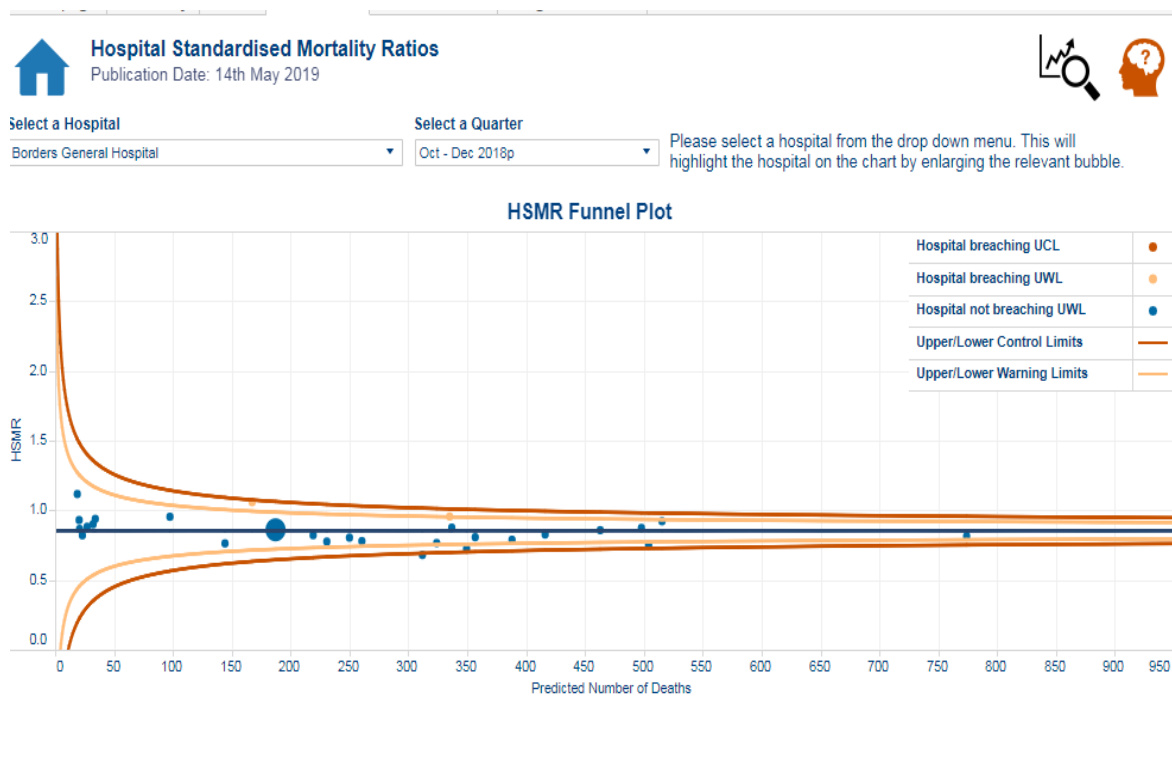
- There has been a reduction in NHS Borders Q3 HSMR compared to the previous quarter confirmed data of 0.93 (0.94 was provisional based on HSMR returns at 11th January 2019)
- NHS Borders HSMR for Q3 in 2017 was 0.87

The previous HSMR report from Quarter 2 triggered a letter from HIS highlighting NHS Borders as an outlier and whilst not expecting any response, it was agreed locally that a review of case notes should be undertaken, excluding the 33 deaths which occurred in the Margaret Kerr Unit (MKU) This review is underway and any learning will be shared across teams.

Local Context

The figures for Borders General Hospital also include our MKU which is a specialist palliative care and end-of-life care unit. Changes in the provision of this type of care are not explicitly factored into the case mix adjustment of HSMR due to existing practices for capturing information, hence the growing number of patients in these cohorts, may be influencing our HSMR upwards as they fall into a higher risk category in terms of the model predicting their probability of death.





Future Reporting

Having carried out a review of the methodology, ISD intends to make the following changes and reporting from August 2019 onwards:

Change 1

In line with previously agreed methodology, re-base the model as planned to a new initial three year reference period of April 2016- March 2019 (current reference period is January 2011- December 2013). Further to this, advance the reference period by three months for each future reporting period.

Impact

- This will ensure that the Scottish HSMR is always representative of current outcomes and reflective of changing case mix and provision of services
- The focus of HSMR will be to allow hospitals to compare their outcomes to the Scottish average at a fixed point in time, in line with the English Summary Hospital-level Mortality Indicator (SHMI), rather than monitor trends in HSMR over time
- The Scottish HSMR will have a baseline of 1.0, making the interpretation more intuitive and comparison with individual hospitals more transparent. For example, if a hospital's HSMR is 0.85, it has 15% fewer deaths than predicted. Similarly an HSMR of 1.20 would indicate 20% more deaths than predicted
- National trends in mortality will continue to be monitored using crude mortality

Change 2

Use aggregated speciality groupings within the modelling. At present, two overarching groups are used to categorise the patient activity

Impact

- Moving to a more specific grouping improves performance of the model
- Provides more detailed groupings for further in-depth analysis

Change 3

Using a twelve month reporting period – rather than three months at present- when drawing comparisons against the Scottish average

Impact

- This will smooth out seasonal variations and provide a larger cohort of patients for smaller hospitals thus reducing variation in the reporting of HSMR
- HSMR will be reported alongside longer term quarterly- based crude mortality trends and other contextual indicators

Healthcare Improvement Scotland (HIS) will continue to monitor HSMR figures in the context of their data/ intelligence. However, they will no longer routinely engage formally with an NHS Board on the sole basis of a high/ increasing HSMR.

CLINICAL EFFECTIVENESS

Reporting has now ceased on the monthly Senior Charge Nurse dashboard in order to release time to allow the provision of data & analytical support to the Financial Turnaround Programme. The clinical information co-ordinator within the CG&Q team is currently supporting the PMO one and a half days per week. To date the initial focus has been on sourcing data for High Level Activity KPI's and creating temporary dashboards to visualise this. The longer aim term is to create a suite of dashboards & measures using the business intelligence tool Tableau but currently teams are still in the training phase for this product.

CG&Q are currently scoping out numbers, location and background of staff across the organisation with a quality improvement (QI) qualification. The team are also collecting information on the types and numbers of QI projects being undertaken to review any duplication of effort and also put staff in touch with others who have a similar focus for improvement work to ensure collaborative working for best results.

PERSON-CENTRED HEALTH AND CARE**Feedback and complaints**

NHS Borders gathers patient feedback in a number of different ways; this includes but is not limited to:

- Patients, carers and relatives can provide feedback to any NHS Borders' member of staff who will be happy to help them. Correspondence can be received via letter, email, telephone and in person. Alternatively they can contact the Feedback and Complaints Team
- Patient feedback provided by other organisations
- Online feedback through Care Opinion www.careopinion.org.uk
- NHS Borders website
- Public Involvement Groups
- National patient experience surveys
- Leadership walkrounds in clinical areas seek to speak directly with patients, carers and relatives to hear their experience
- Daily conversations at ward level with patients and families – led by Senior Charge Nurses as co-ordinators of care

Based on feedback received during 2018/19 we know that the majority of our patients are satisfied with the care and treatment provided by NHS Borders. However, on occasion the care and treatment provided does fall short of the high standards we expect. When this happens it is very important that we hear about it to enable learning from mistakes made to inform how we improve the way we do things in the future.

‘Two Minutes of Your Time’

We continue to use our, ‘Two Minutes of Your Time’ feedback questionnaire to gather anonymous patient, carer and visitor feedback within the Borders General Hospital (BGH), four Mental Health units and the four Community Hospitals.

Patient Feedback Volunteers

NHS Borders has patient feedback volunteers to support clinical teams to gather feedback from patients, carers and relatives about their services. Feedback is gathered in the BGH Discharge Lounge, Outpatients Departments, eight of our BGH inpatient wards and one of our community hospitals. Information gathered by the volunteers is reported back to the relevant areas on a regular basis or at the time that feedback was received.

Charts 1 to 3 on the following pages represent the data gathered, between April 2018 and March 2019, from over 4000 patient feedback questionnaires. This was carried out using patient feedback volunteers and the “2 minutes of your time” feedback boxes within several departments and wards in the hospital to engage with patients, relatives and visitors.

Chart 1 below demonstrates the percentage of patients, carers and relatives that were satisfied with the care and treatment provided. The ‘Yes’ response has mostly remained steady throughout although this was lower between October 2017 and December 2017 again in April 2018 and during the period January to March 2019.

Chart 1

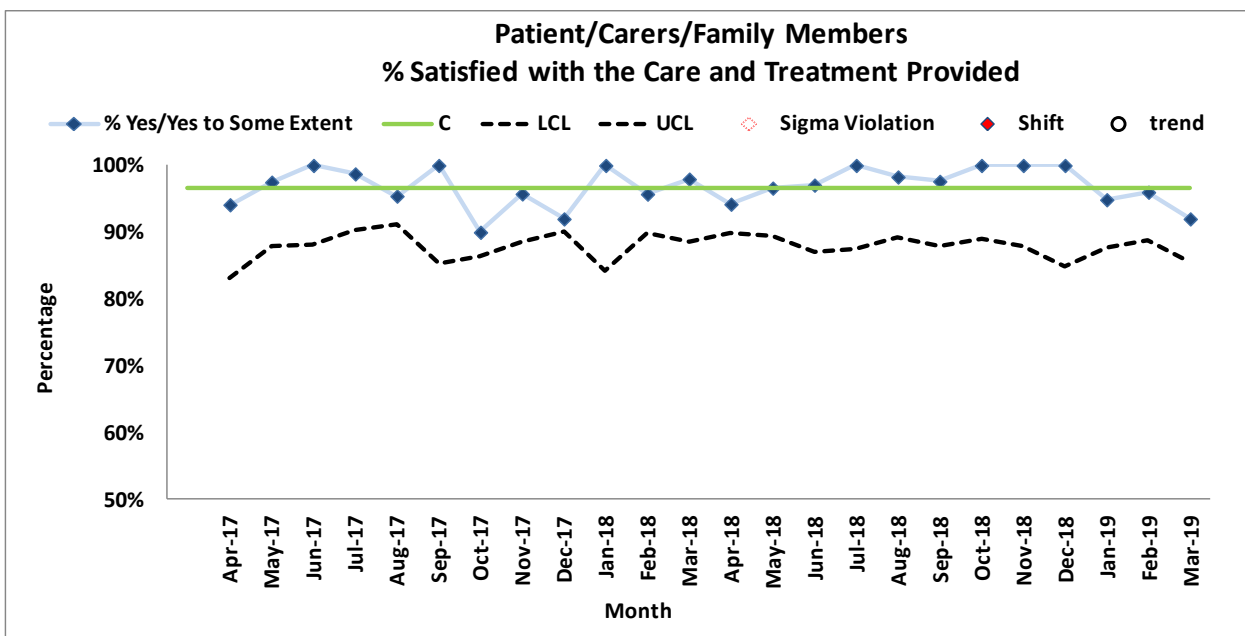


Chart 2 below shows the percentage of patients, carers and relatives who thought the staff that provided the care understood what mattered to the patient. The 'Yes' response has remained fairly steady throughout 2018/19.

Chart 2

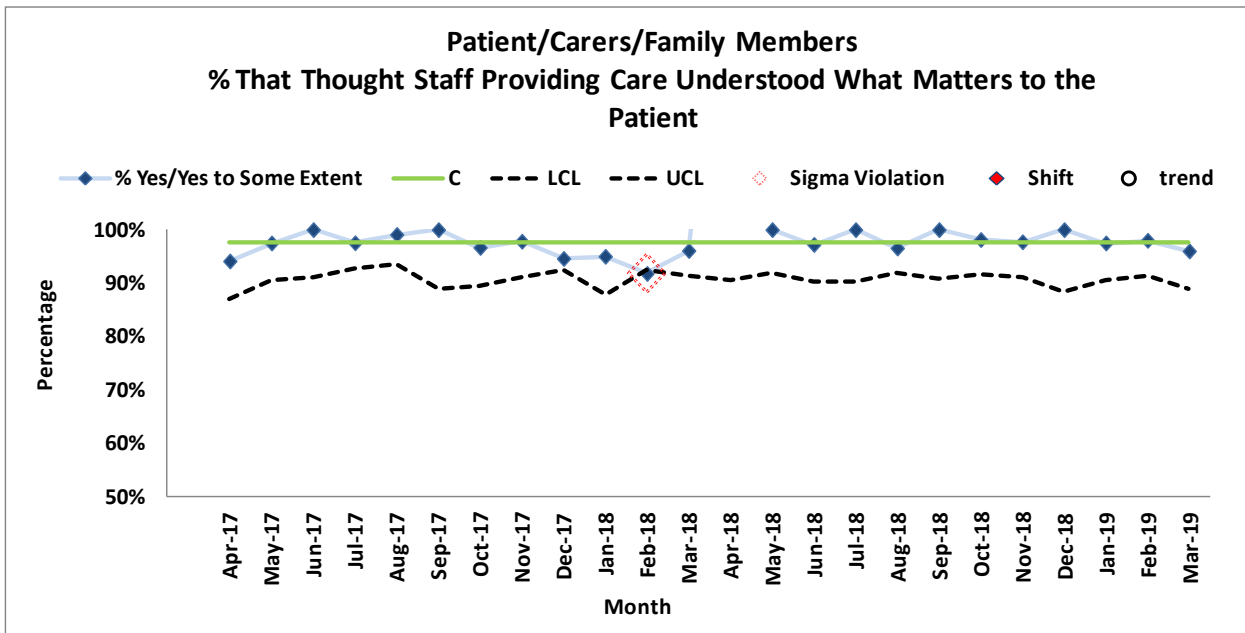
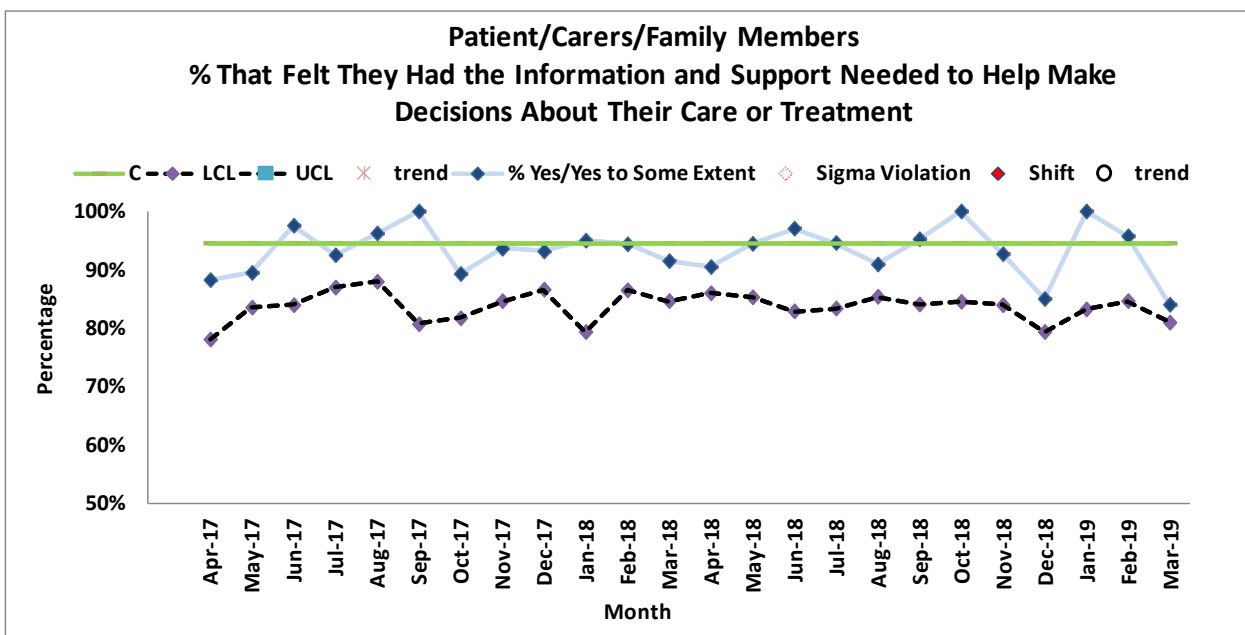


Chart 3 below demonstrates the percentage of patients, carers and relatives who thought the patient always had the information and support needed to make decisions about their care or treatment. The 'Yes' responses have been quite variable dropping quite considerably during December 2018 and March 2019.

Chart 3



Learning from complaints

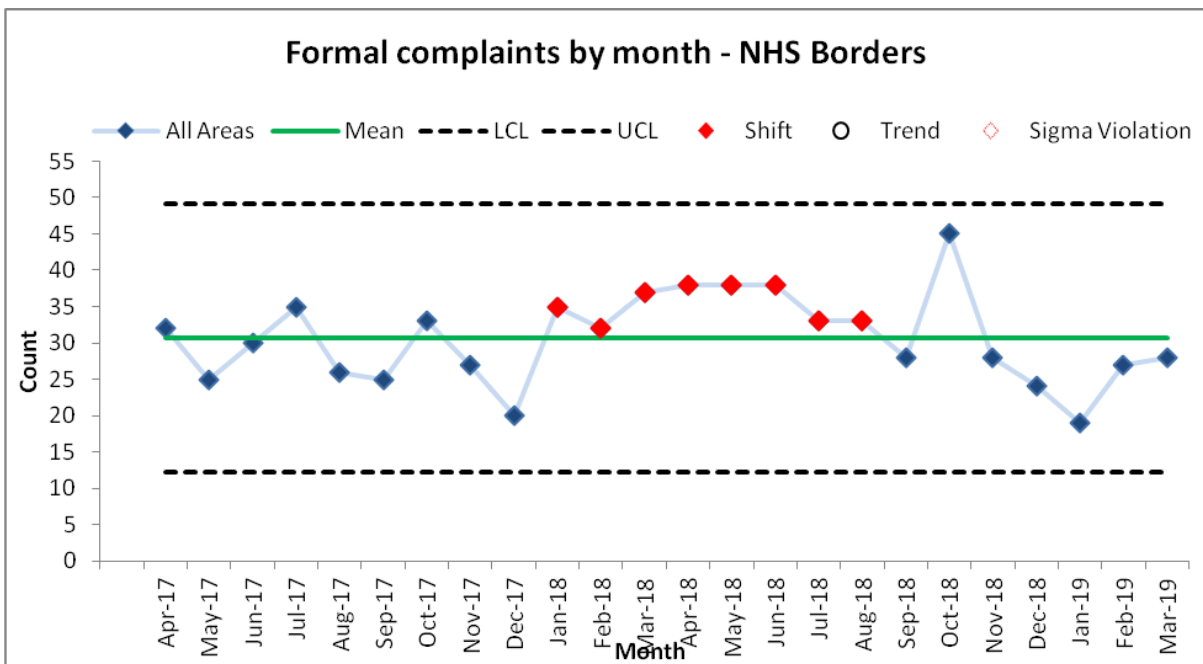
NHS Borders encourages a culture of openness. Patient feedback is routinely used along with other sources of information to inform service improvements.

For all complaints responded to, an assessment is made as to whether the complaint is upheld, partly upheld or not upheld. Where a complaint is either upheld or partly upheld the relevant services agree an improvement plan that is monitored by the General Manager for each service. Complaints are also a standard agenda item on the meetings of each of the service clinical governance groups. Either the Chief Executive, Medical Director or Director of Nursing, Midwifery & Acute Services read and sign every Stage 2 complaint response. They are explicitly committed to improving the experience of patients, carers and relatives and improving the quality of our services.

Although it is not always possible to attribute all improvements to patient, carer or relative feedback, the following are examples of where improvements have been made in response to feedback, complaints and Care Opinion stories:

- Introduction of mealtime volunteers
- Guidance for the management of elbow fractures reviewed
- Signposting to the use of Care Opinion made more visible within the Emergency Department
- Additional sepsis safety-netting guidance in place for Borders Emergency Care Service's clinical co-ordinators
- Adjustments made to doorway into gents toilet within reception area of Borders General Hospital to ensure privacy
- Radiology Department are currently setting up a system where our scans can be reported by an external company in order to reduce the time patients are waiting for results.
- Emergency Department are now displaying posters that advise families who have not been called through to the patient's bedside within 30 minutes to ask at Reception why not.
- Letters sent to patients for outpatient appointments or surgery also now include a link to the NHS Borders website which details the current waiting times for each service.
- Now normal practice within paediatrics to routinely copy all clinic letters to parents.
- Changes to electronic patient administration system (TrakCare) to ensure staff booking appointments are able to see any alerts about requirement to book assistance such as interpreters.
- A named nurse should be clearly displayed above every bed in the hospital.

A total of 379 complaints were received between April 2018 and March 2019. When a comparison is made with 2017/18, this shows there has been an increase of 26 in the number of complaints received during the year. The chart below shows the number of formal complaints received by month between April 2017 and March 2019.

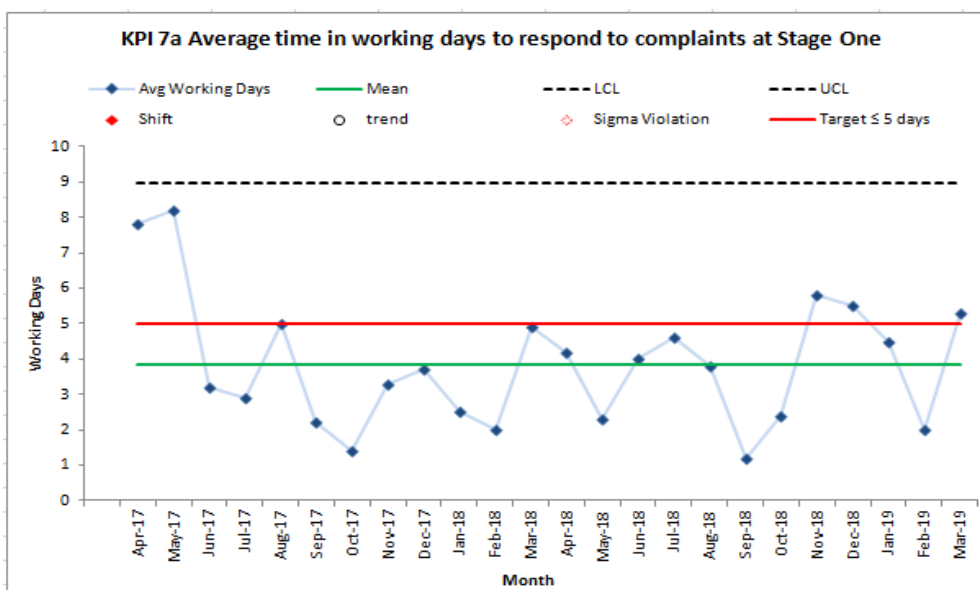


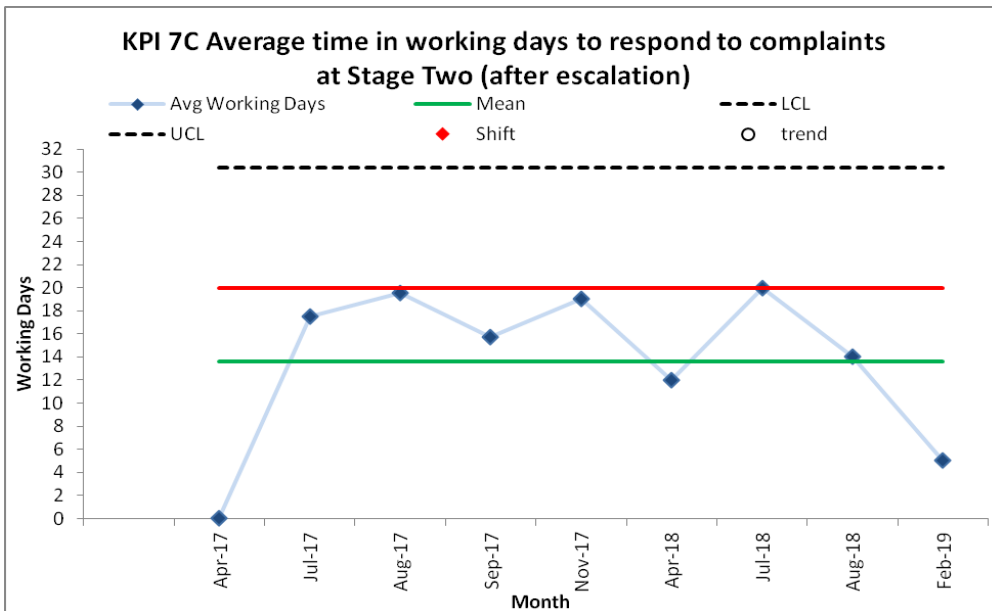
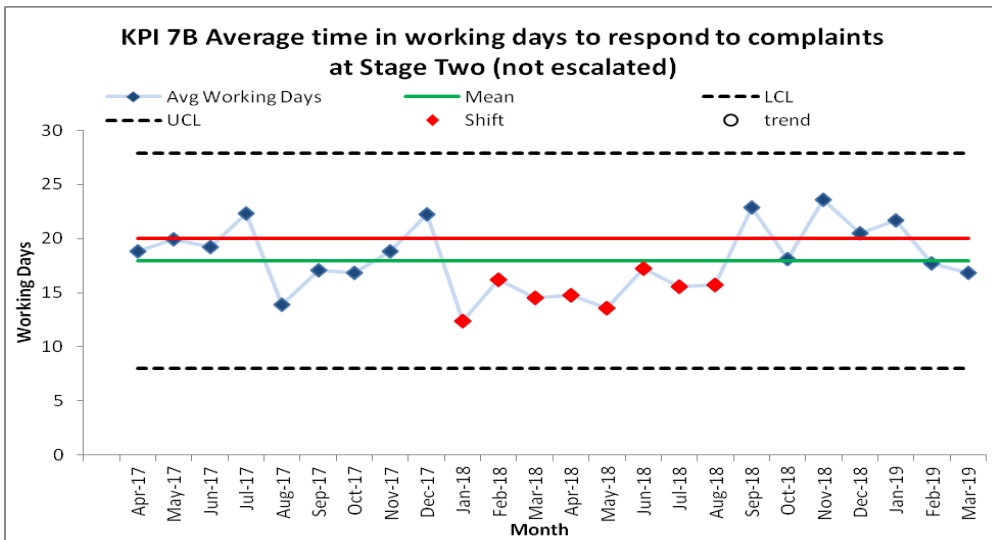
Out of the 379 complaints received, 260 related to the Borders General Hospital, 40 related to Primary & Community Services, 50 related to Mental Health and 29 related to Support Services.

Whilst the top five themes for complaints have remained the same, the totals for each theme have increased in number.

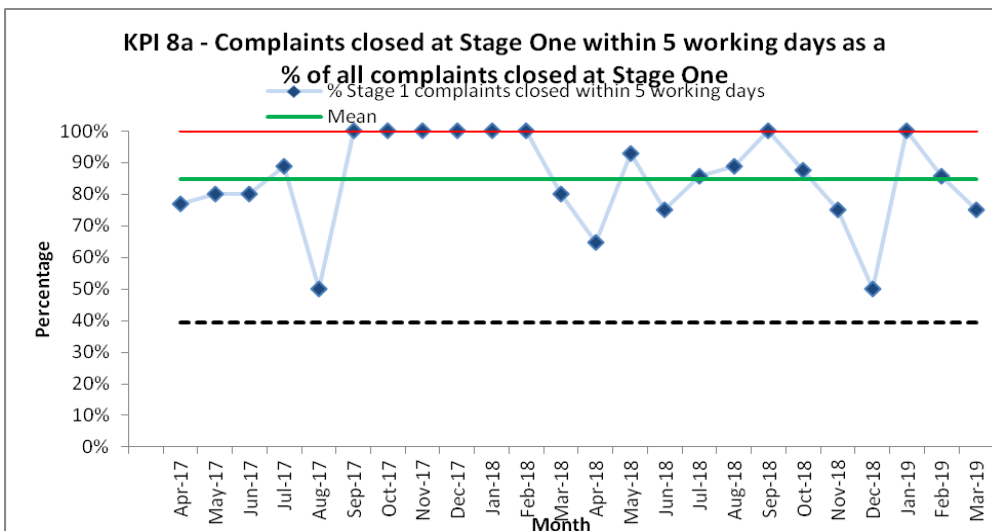
Top 5 Issues	Total 2017/18	Total 2018/19
Attitude and Behaviour	152	189
Clinical Treatment	194	206
Communication – Oral	76	101
Date of Appointment	52	56
Communication – Written	47	60

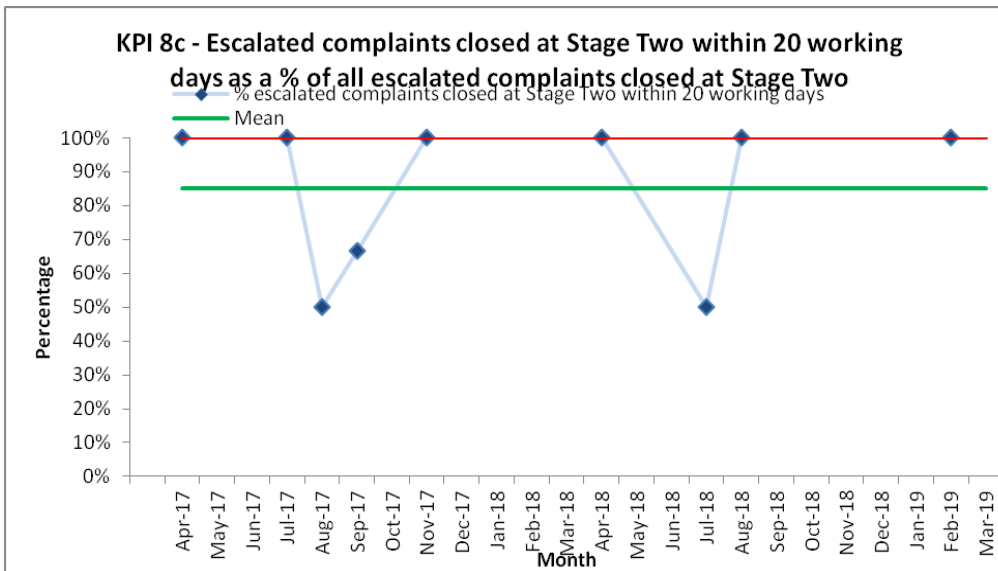
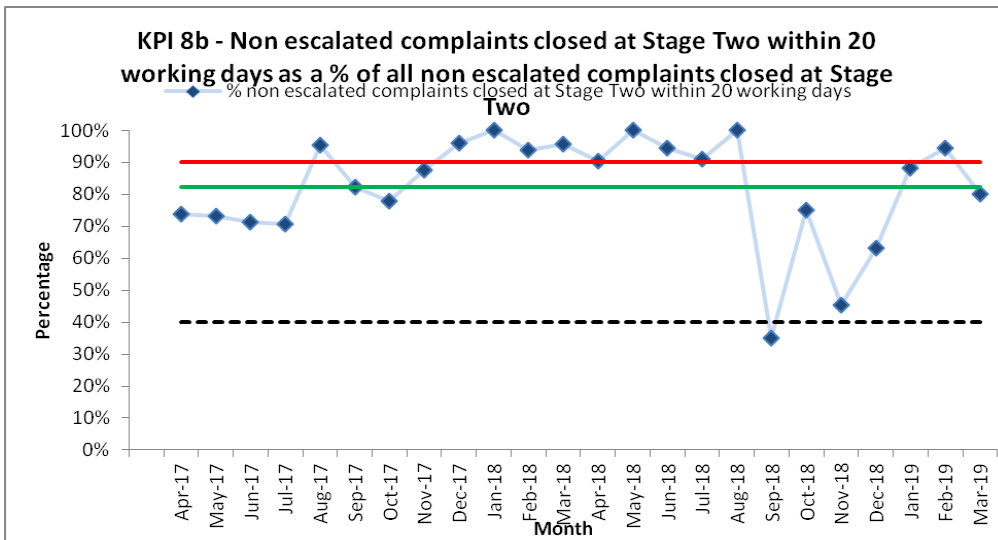
Average response times





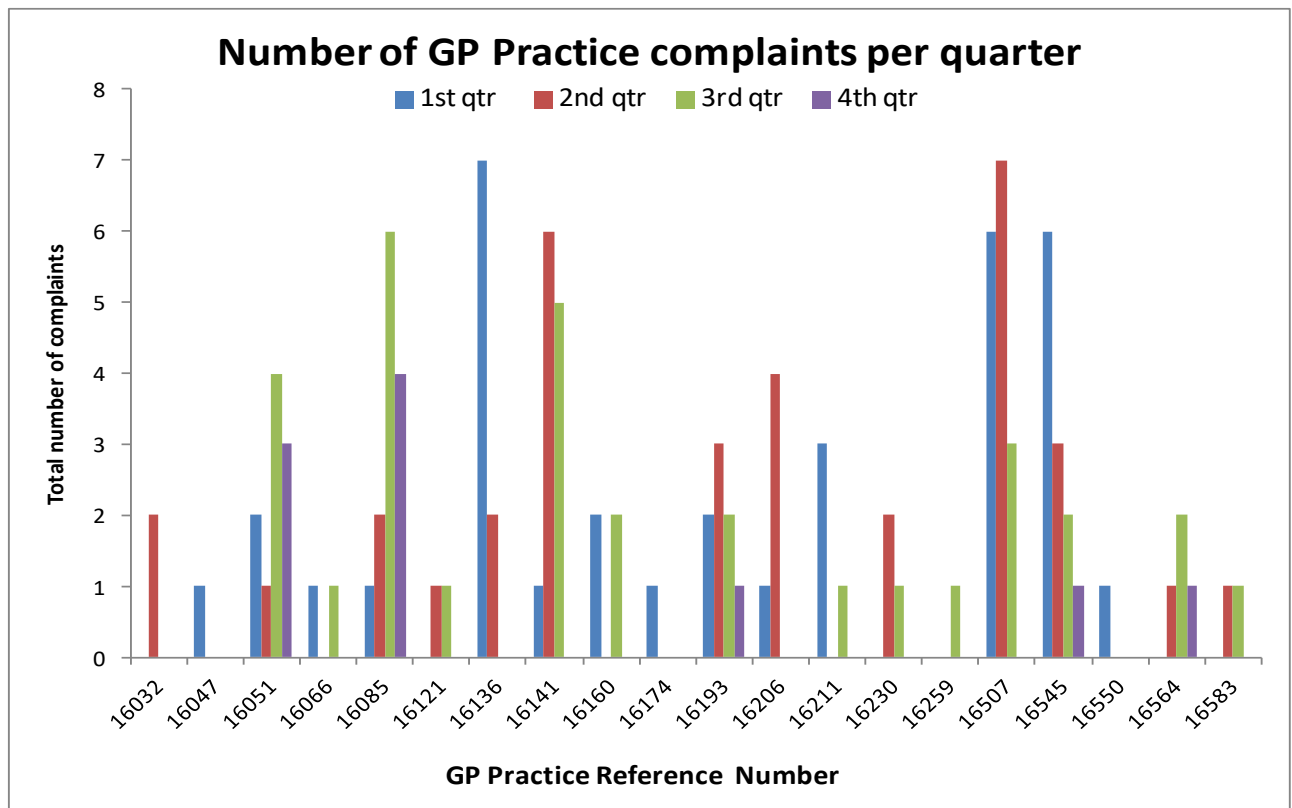
Complaints closed in full within the timescales



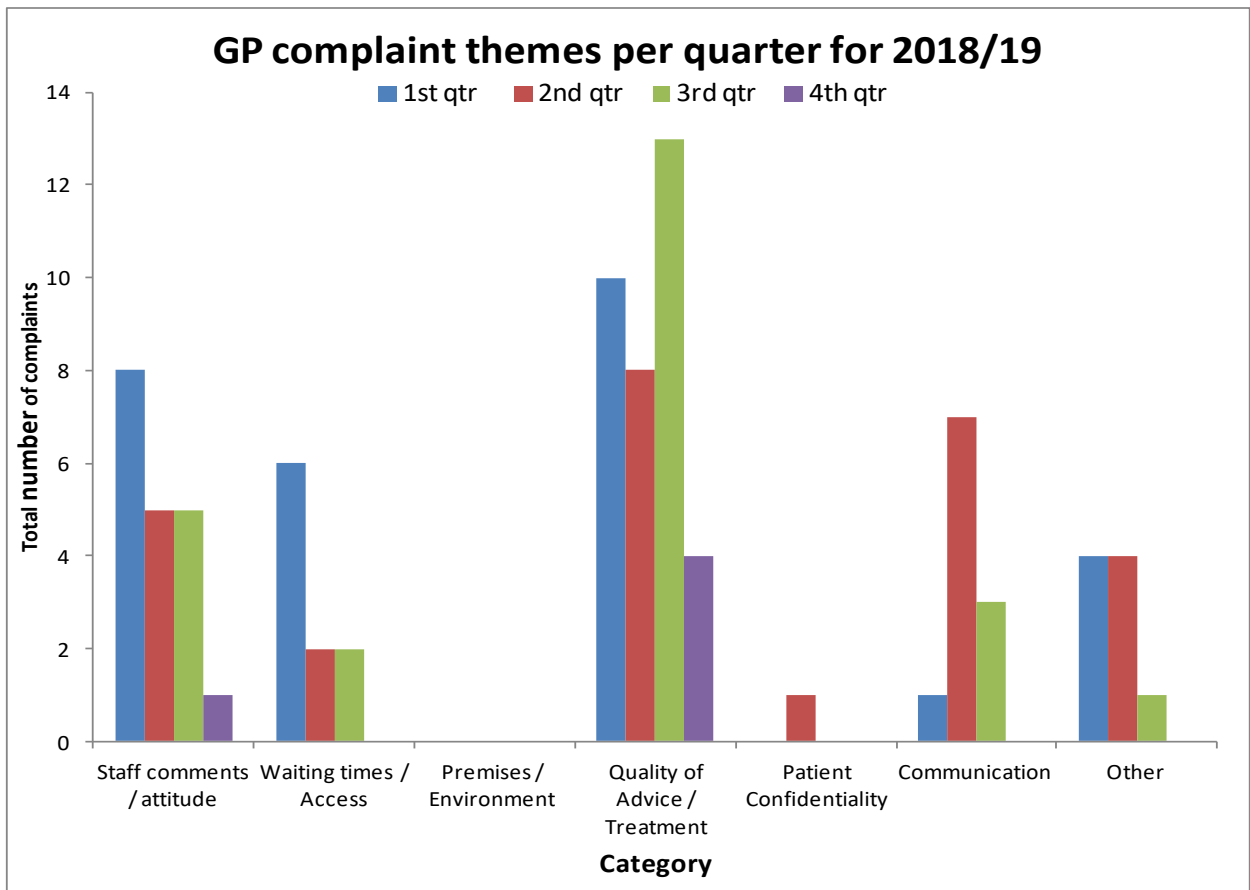
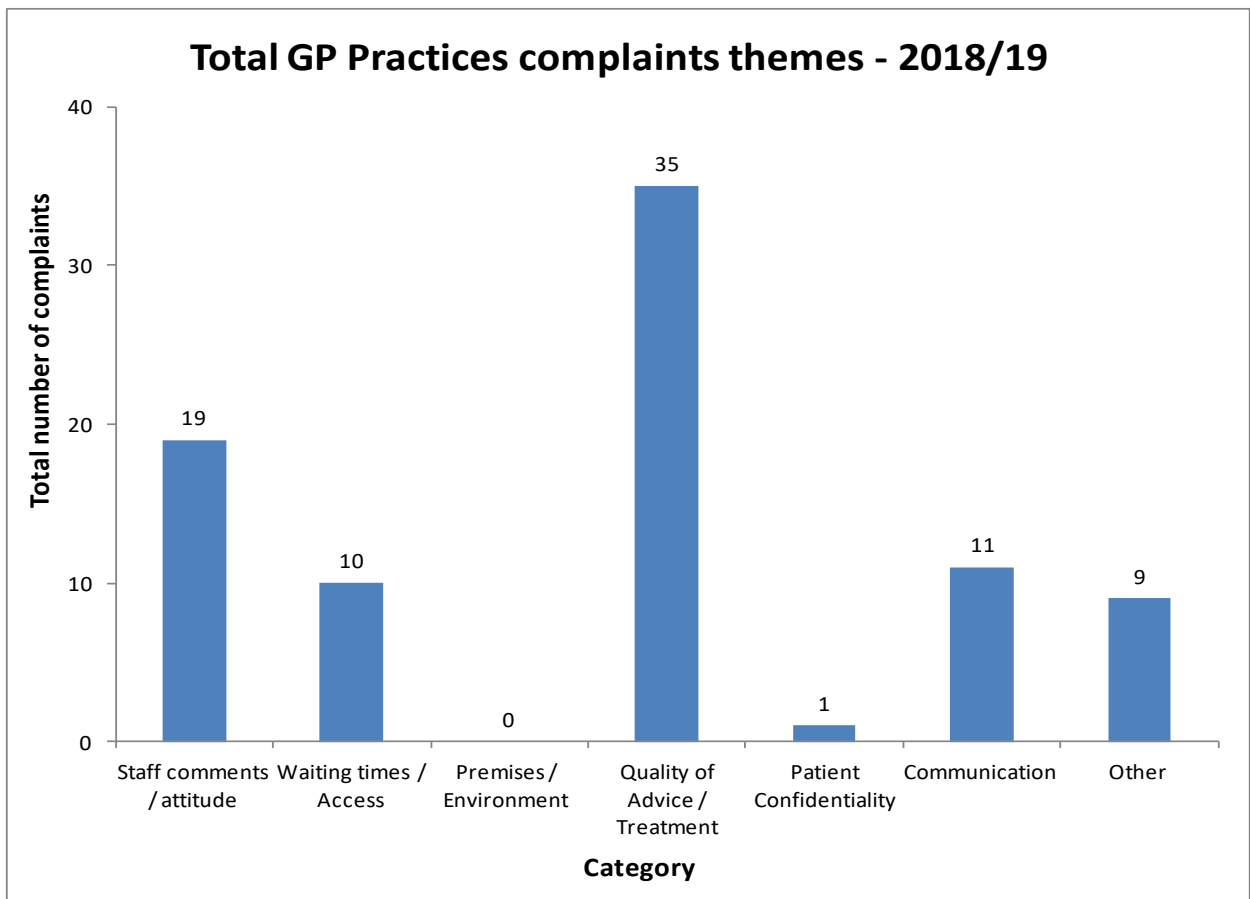


General Practice Complaints 2019-2019

The tables below detail the number of complaints from general practice from April 2018-March 2019 as well as the themes identified.

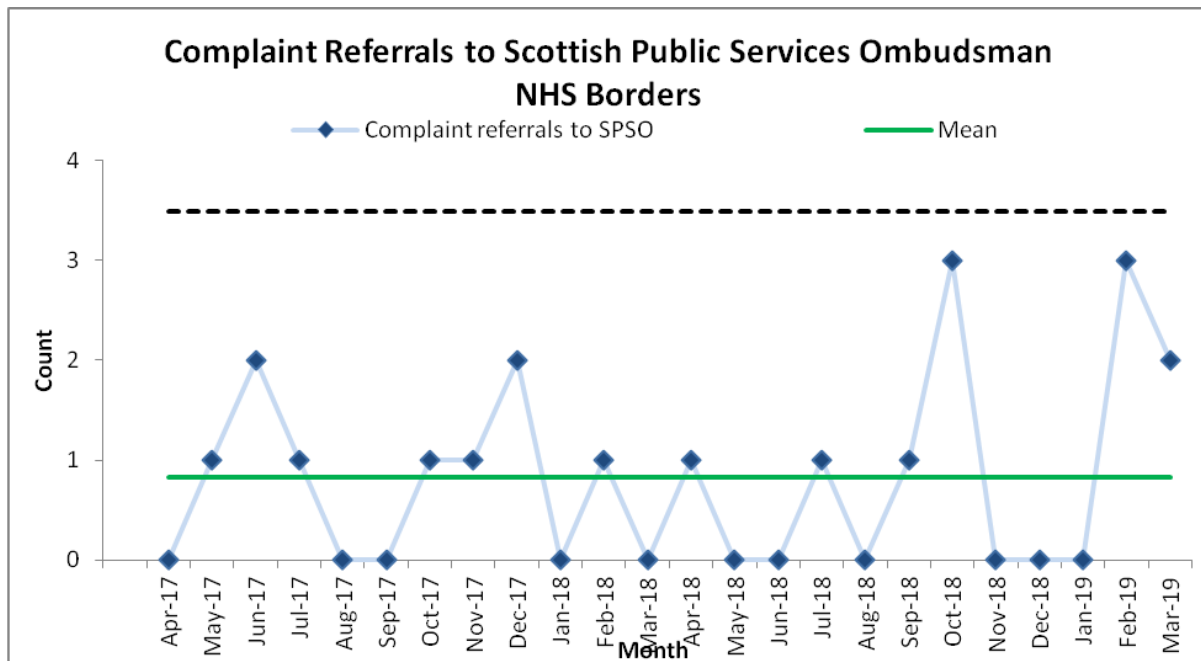


Previously we have only been able to share quarterly snapshots of data but have combined the quarterly reports in to an annual summary. The highest numbers of complaints are linked to communication, staff attitude and quality of advice/ treatment, however, the total number of complaints in 2018/19 were 125 across all practices.



Scottish public services ombudsman (SPSO)

The chart below outlines the referrals accepted by the SPSO between April 2017 and March 2019. In 2018/19, there were 11 referrals made to the SPSO which is an increase of 2 from the 9 made during 2017/18:



The following decisions and recommendations were received by the SPSO between April 2018 and March 2019 for cases investigated by them in relation to complaints made to NHS Borders:

SPSO Case Reference 201708429	Progress
Case was not upheld	Closed
SPSO Case Reference 201703851	Progress
Apologise for the failing to consider further investigations despite the persistence of pain.	Action plan submitted taking account of the recommendations to the SPSO on 12 December 2018.
Confirmation that clinical staff involved in this case have considered it as part of their next reflective learning discussion in their next annual appraisal. Evidence that the case has been reviewed in the next Morbidity and Mortality (M&M) meeting.	
SPSO Case Reference 201700001	Progress
Apologise for the failings in the patient's agreed care plan and poor record keeping.	NHS Borders submitted an action plan taking account of the recommendations to the SPSO on 5
When significant deviation from agreed care plans occurs, this should be escalated to the Responsible Medical Officer for discussion and a record made of what the response to this should be.	
Provide evidence of the action already taken.	

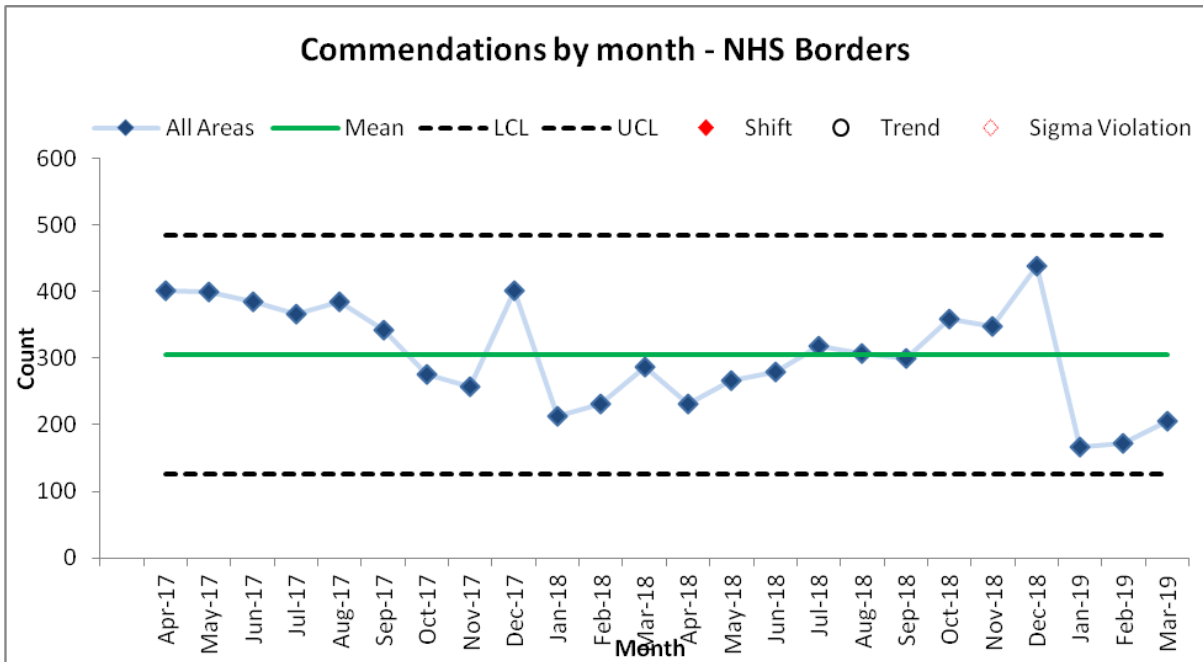
	September 2018.
Evidence to show what consideration has been given to implementing measures to improve communication with relatives/carers.	

SPSO Case Reference 201703340	Progress
Apologise for the failings in relation to the patient's care and treatment.	Action plan submitted taking account of the recommendations to the SPSO on 29 November 2018.
Patients admitted to hospital should receive CT scanning in line with Scottish Stroke Care Standards.	
There should be ongoing structured assessment, management and review of patients with cognitive impairment and delirium in hospital settings.	
There should be a comprehensive approach to identifying and reviewing care needs and how these needs will be met during a patient's stay in hospital.	
The care needs of patients in relation to continence assessment and management in BGH should be appropriately met.	
The 'Getting to Know Me' document should be completed and used to inform a person centred care plan.	
Patients with a serious chronic condition should have follow-up as agreed. Where it is decided to stop the follow-up appointments for a patient, the patient should be informed of this and the reasons for this.	

SPSO Case Reference 201706740	Progress
Apologise for not fully assessing patient or following guidance which led to a delay in being screened for sepsis. The apology should also address the communication failures identified by the SPSO.	Action plan submitted taking account of the recommendations to the SPSO on 7 December 2018. On 10 December 2018 the SPSO confirmed that they were satisfied with the contents of the action plan and therefore closed the case.
Patients whose NEWS score triggers action should be appropriately assessed including screening for sepsis and delirium.	
Patients and/or their carers should receive appropriate information about their condition in a way that suits their communication needs.	

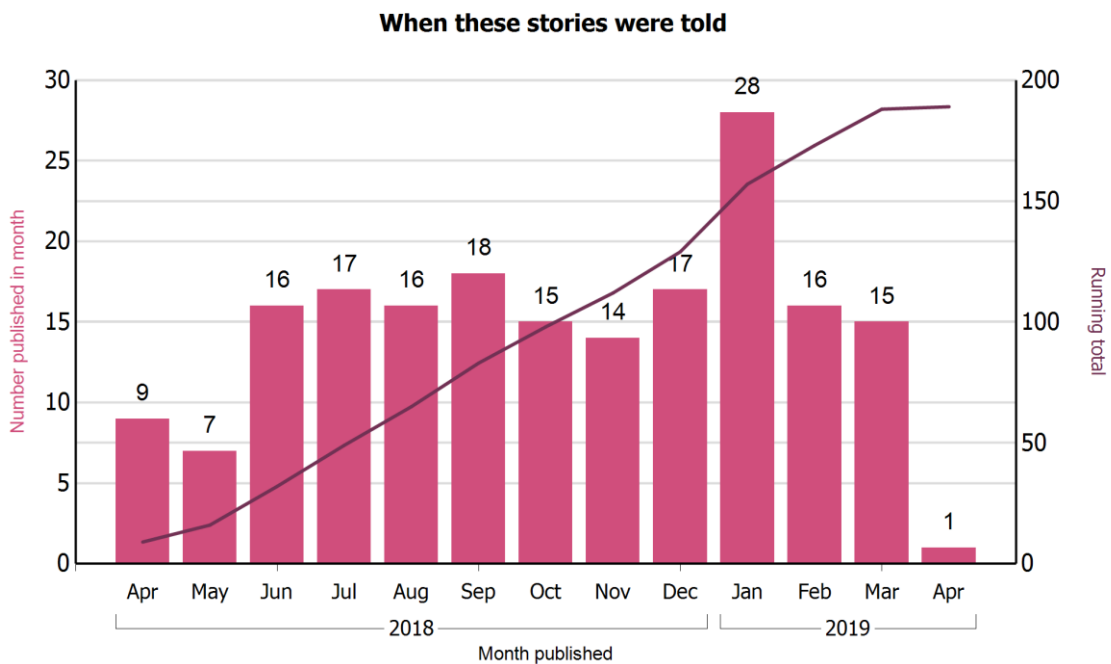
Commendations

The table below shows that NHS Borders received 3393 commendations in 2018/19 which is less than the 3860 received in 2017/18.

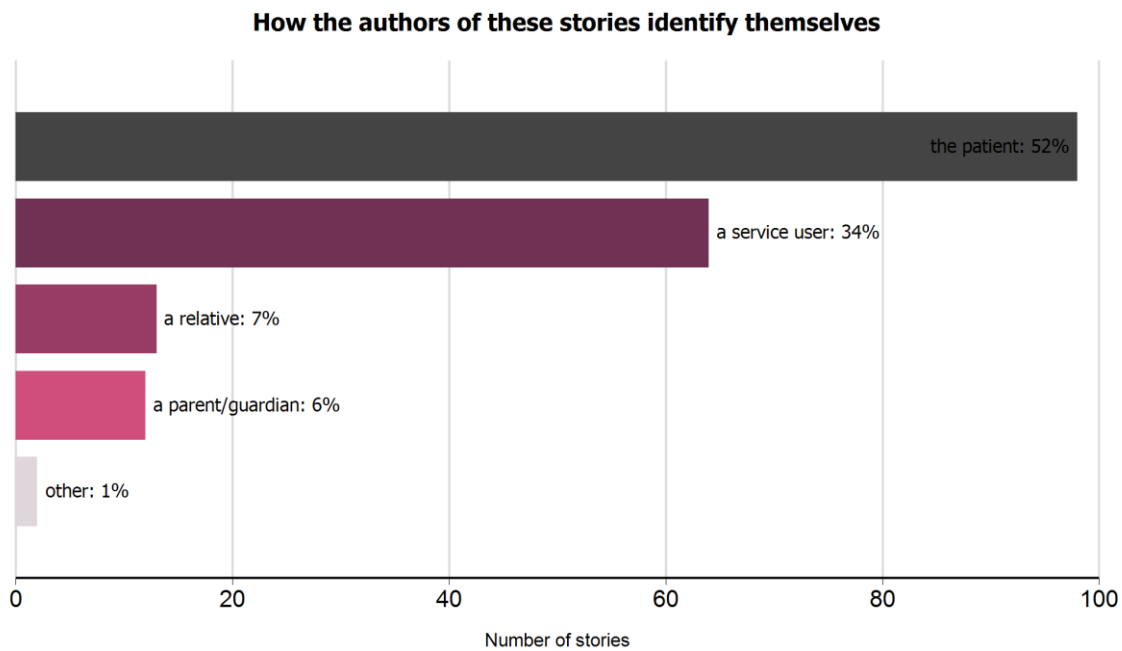


Care Opinion

Between 1 April 2018 and 31 March 2019, 189 stories were shared on Care Opinion about NHS Borders. At the time of preparing this report, these stories have been viewed on Care Opinion 30,750 times in total. 81% of the stories shared were positive stories. The following charts have been produced by the Care Opinion website.



The chart below shows who has written the stories about NHS Borders with 52% having been written by the patient themselves.




Volunteering

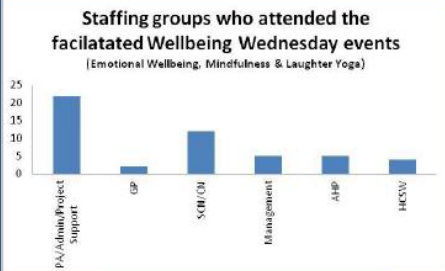
The Voluntary Services Manager together with the General Manager for Planned Care and Commissioning implemented a 'Wellbeing Wednesday Programme' to help boost staff moral during the Wednesdays between January- March. A schedule was devised providing activities / information stand for staff members. The programme was launched on the 9 January with Borders College beauty students providing arm and hand massages together with mini manicures (for non clinical staff). Our volunteers supported this programme by facilitating different events such as Emotional Intelligence and Mindfulness, please see flash report below summarising the 'Wellbeing Wednesday' programme.

The main aim of Wellbeing Wednesday was to boost staff moral between the winter months of January – March and focus on providing staff with a weekly programme including a variety of events. Wellbeing Wednesday was launched on the 9th January by the Borders College students providing hand / arm massages and mini manicures (non clinical staff) to over 40 members of staff within a 3 hour timeframe.


WELLBEING WEDNESDAY FLASH REPORT JANUARY – MARCH 2019

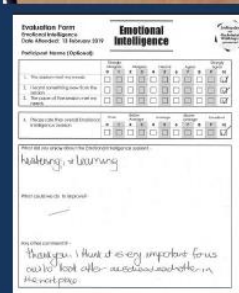



Staffing groups who attended the facilitated Wellbeing Wednesday events (Emotional Wellbeing, Mindfulness & Laughter Yoga)



Staffing Group	Number of Staff
PA/Admin/Project Support	22
GP	2
SCH/OH	12
Management	5
AHP	5
HCWV	5









Highlights:

- 🌟 Emotional Wellbeing
- 🌟 Appreciation Stations
- 🌟 Mindfulness
- 🌟 Laughter Yoga
- 🌟 Reading as an aid to wellbeing
- 🌟 Walking groups
- 🌟 Colouring
- 🌟 Cupcakes
- 🌟 Acts of kindness
- 🌟 Top tips
- 🌟 Wellbeing Apps
- 🌟 Thank you notes
- 🌟 'Food for Thought' gestures
- 🌟 Informing staff of NHS discounts
- 🌟 Showcasing GREATix
- 🌟 'Hangry' boxes
- 🌟 Little bags of loveliness
- 🌟 Happy Folders





Thank you to everyone who participated or helped forward on small acts of kindness with special thanks to our staff members and volunteers who supported the programme. We hope you will continue to stay well and support your colleagues.

#yourpart #acts of kindness #wellbeing

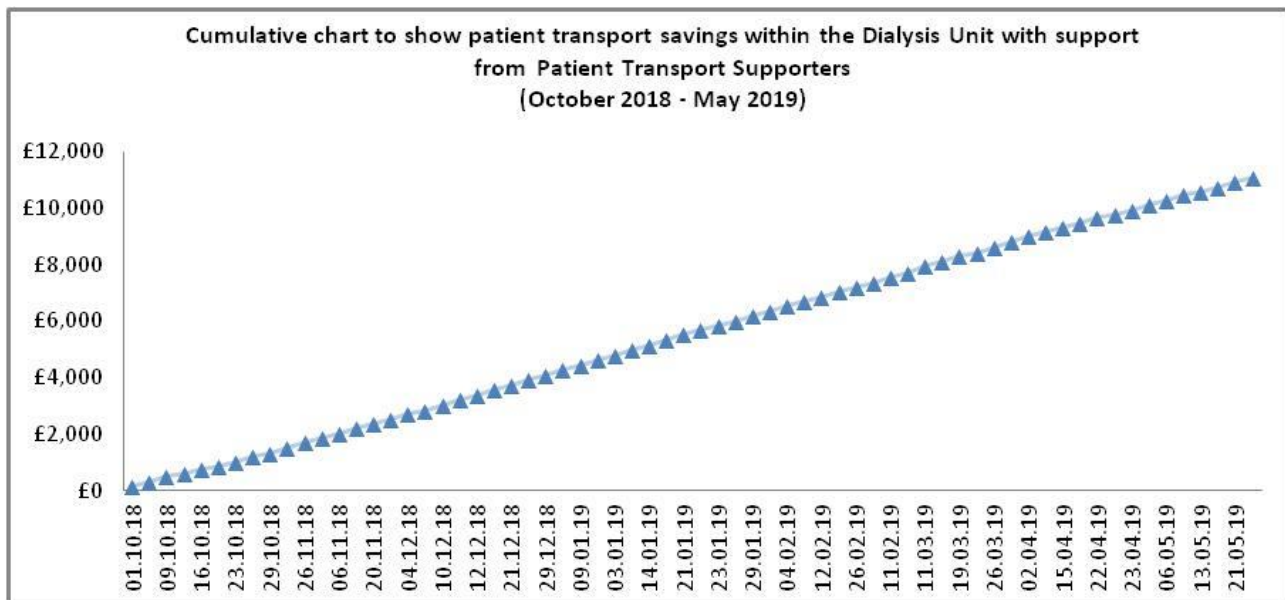
Health Improvement Scotland volunteered to produce short films of 2 different types of volunteering roles, mealtime volunteers and Breastfeeding Peer Supporters. These short films were greatly received after being showcased at the Volunteer Managers Network event in Edinburgh together with the Strategy & Performance Committee.

As part of volunteering week the Voluntary Services Manager together with 2 Breastfeeding Peer Supporter volunteers are invited to attend the Cross Party Group at Scottish Parliament in June themed 'Time to Celebrate' where we will have the opportunity to showcase the short film illustrating the Breastfeeding Peer Supporter volunteering role.

Volunteer driver programme

The Volunteer Driver Programme commenced in September 2018 within the Dialysis Unit. Due to the financial pressures the organisation is facing we are looking to extend the Volunteer Driver Programme into the Discharge Lounge. At present we have 6 Patient Transport Support volunteers. To expand the volunteer driver programme within the Discharge Lounge the Voluntary Services Manager is liaising with the Unscheduled Care team to ensure a robust process is in place.

The table below demonstrates patient transport savings within the Dialysis Unit with support from Patient Transport Supporters from October 2018 to May 2019.



The table below summarises the savings during this time frame by demonstrating the projected taxi invoices against the volunteer travel expenses. This is a considerable saving over a full financial year.

Projected Taxi Invoices	£15,561.50
Volunteer expenses	£4,478.91
Savings	£11,082.59

RESEARCH GOVERNANCE

Due to staff absence and the departure of the Research Governance Coordinator the approval process in NHS Borders was not meeting national targets set by the Chief Scientist Office (CSO). With support from NHS Lothian the approval process is now processing new study requests and amendments to existing studies in a timely manner. The job description for Research Governance Co-ordinator was revised and submitted for job evaluation to ensure it accurately reflected the roles and responsibilities of the post. It has now been re-banded and is in line with similar posts across Scotland. The post of Research Governance Manager has been advertised and shortlisting will be taking place soon.

Changes to national processes for reporting research recruitment changed in April. A letter has been sent to all local investigators advising them of the need to submit recruitment figures at the end of each month to R&D for upload to the national system. The national approval process for submitting research projects to Ethics and R&D is changing on the 5th June. There will be changes to the documentation that researchers complete. It is expected that some local processes will have to be changed, however final processes have not been announced, so the impact cannot be assessed at present.

CSO annual reports and review

The CSO has split its annual research submission into 2 separate reports for activity and expenditure. The activity report was submitted by NHS Borders in April. The expenditure report was submitted before the deadline of 31st May. The annual review meeting between the CSO and the Board will take place on Monday 1st July 2019.