Borders NHS Board

Meeting Date: 5 December 2019

Approved by:	Cliff Sharp, Medical Director
Author:	Laura Jones, Head of Clinical Governance and Quality

QUALITY & CLINICAL GOVERNANCE FULL REPORT NOVEMBER 2019

Purpose of Report:

The purpose of this report is to provide the NHS Borders Board with an exception report on activities and progress across areas of:-

- Patient safety
- Clinical effectiveness
- Research and innovation
- Person centred health and care

Recommendations:

The Board is asked to **note** this report.

Approval Pathways:

This report has been reviewed by the Board Executive Team.

Executive Summary:

This report reports on the following areas across the Quality and Clinical Governance portfolio:

- Patient safety
  - Scottish Patient Safety Programme (SPSP)
  - Adverse events
- Clinical effectiveness
  - Inspection
  - Clinical audit
  - Excellence in care
- Research and innovation
  - Research governance
  - Innovation
- Person-centred health and care
  - Patient experience
  - Public involvement
  - Volunteering

Impact of item/issues on:

Strategic Context	The 2020 Vision for Healthcare in Scotland and NHS

	Borders Corporate Objectives guide this report.
Patient Safety/Clinical Impact	Patient safety, person-centred care, clinical effectiveness, research and innovation, and quality improvement sit within the Quality and Clinical Governance portfolio.
Staffing/Workforce	Service and activities are provided within agreed resources and staffing parameters
Finance/Resources	Service and activities are provided within agreed resources and staffing parameters.
Risk Implications	In compliance as required.
Equality and Diversity	Compliant.
Consultation	The content of this paper is reported to Clinical Boards, Clinical Governance Groups, the Clinical Executive Strategy Group and to the Board Clinical and Public Governance Committees.
Glossary	SPSP- Scottish Patient Safety Programme HIS - Healthcare improvement Scotland HSMR - Hospital Standardised Mortality Rate CGC - Clinical Governance Committee CIF - Clinical Improvement Facilitator BGH - Borders General Hospital NEWS - National Early Warning Score ED - Emergency Department AKI - Acute Kidney Injury FFN - Food, Fluid and Nutrition SOP - Standard Operating Procedure MUST -Malnutrition Universal Screening Tool MCQIC - Maternity and Children Quality Improvement Collaborative SAER - Significant Adverse Event Review DoC - Duty of Candour SAE - Significant Adverse Event EiC - Excellence in Care CAIR - Care Assurance Information Resource SEND - Scottish Executive Nurse Directors ASDNC - Alzheimer Scotland's Dementia Nurse Consultants CSO - Chief Scientists Office NRS - NHS Research Scotland SPSO - Scottish Public Service Ombudsman SHC - Scottish Health Council

PATIENT SAFETY

Scottish Patient Safety Programme (SPSP)

NHS Borders' will be undertaking a self assessment of progress against the Scottish Patient Safety Programme (SPSP) Adult Acute workstream priorities due for submission to Healthcare Improvement Scotland (HIS) in January 2020. These workstreams include medicines, deteriorating patients, falls, pressure ulcers and catheter associated urinary tract infections. In advance of the self-assessment the annual review of the local patient safety workstreams is underway to determine our progress against both local and national safety priority areas and to identify the focus areas for the local safety programmes for the coming year. Updates on some of these workstreams are set out below:

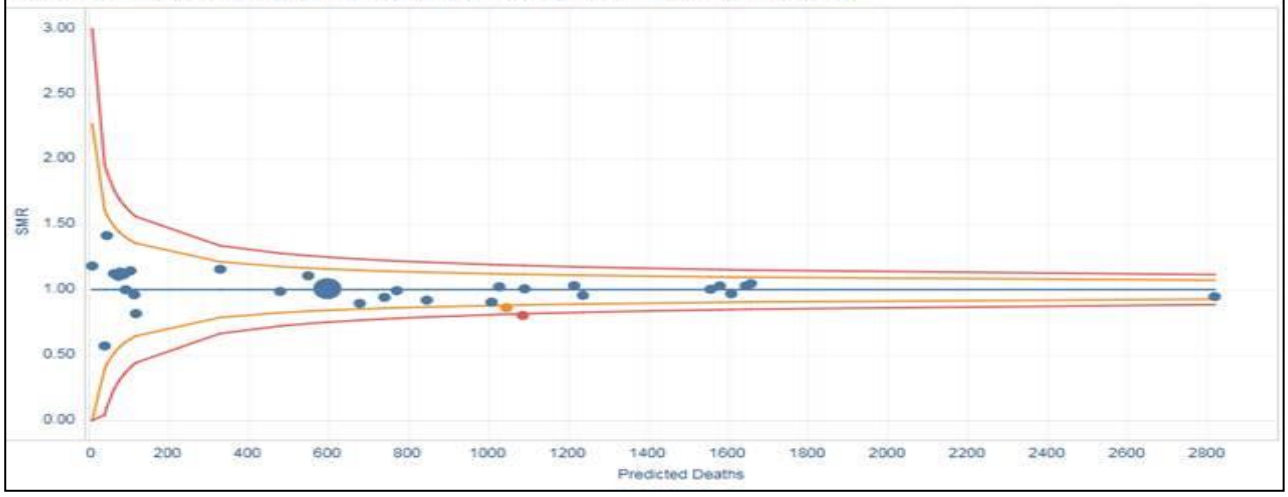
HSMR

The NHS Borders Hospital Standardised Mortality Rate (HSMR) for the second data release under the new methodology is 1.01. This figure covers the period July 2018 to June 2019 and is based on 602 observed deaths divided by 597 predicted deaths. The funnel plot below shows NHS Borders HSMR remains within normal limits based on the single HSMR figure for this period therefore is not a trigger for further investigation.

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR	Comparison to Scotland on the Funnel Plot
Scotland	25,525	25,525	697,417	3.7%	1.00	n/a
NHS Borders	602	597	12,002	5.0%	1.01	n/a
Borders General Hospital	602	597	12,002	5.0%	1.01	●

Funnel Plot by Hospital: July 2018 to June 2019

Allows comparisons to be made between each hospital and the average for Scotland for a particular period.



*Note: NHS Borders HSMR includes deaths within the Margaret Kerr Unit, which is a specialist palliative care and end-of-life care unit.

NHS Border Board Clinical Governance Committee (CGC) have considered the changes to national HSMR methodology and the implications for local governance and reporting. Historical HSMR data is no longer comparable as a result of these changes and it will therefore not be possible to assess performance over time or to compare current performance against pervious performance. In carrying out their assurance role the CGC will continue to monitor HSMR along with a range of additional safety measures to assess the safety and effectiveness of clinical care delivery.

Falls

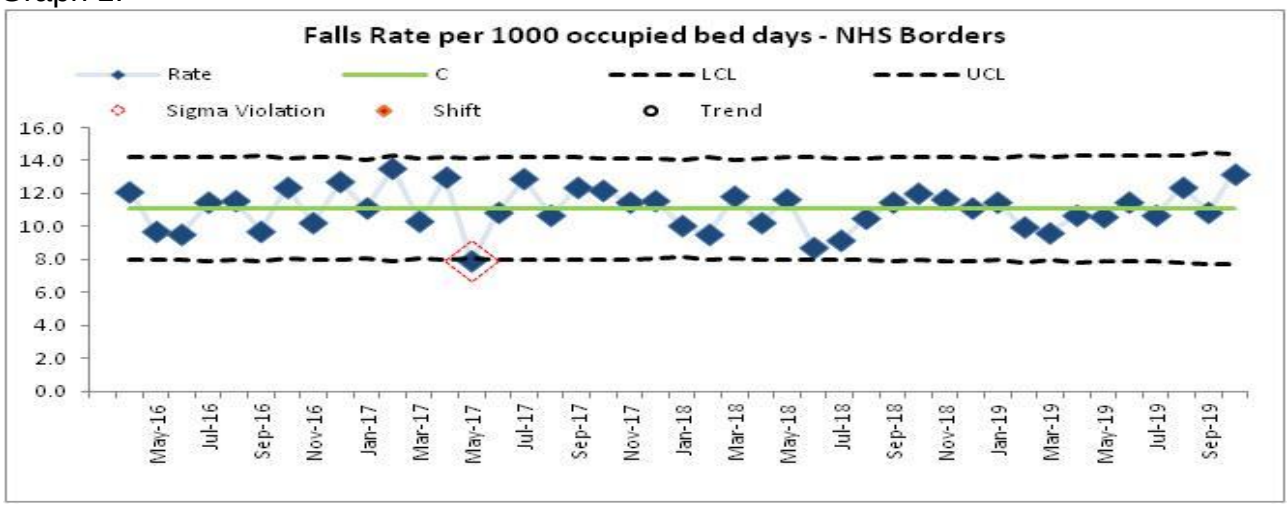
Sandra Pratt has been identified as the strategic lead for falls pending the recruitment to the Associate Director of Allied Health Professions role currently advertised. Sandra will lead on the NHS Borders contribution to the multi-agency work required in this area. A Clinical Improvement Facilitator (CIF) is provided dedicated support to the prevention and management of falls and will focus initial work in three clinical areas across the three Clinical Boards where there is the greatest need.

The CIF has used a quality improvement diagnostic process to identify where there are opportunities for improvement and what our local data shows in terms of rates of falls and falls with harm. The analysis carried out by the CIF has identified that initial targeted support should be deployed to the Borders General Hospital (BGH), Department of Medicine for the Elderly Ward 12, Melburn Lodge and The Knoll Community Hospital.

Two detailed scoping documents (one for all falls and one specific to the Knoll Community Hospital) have been produced that outline how these areas have been selected and the quality improvement work planned for each area. The NHS Borders Back to Basics group have reviewed and agreed the proposals made and improvement work has now commenced.

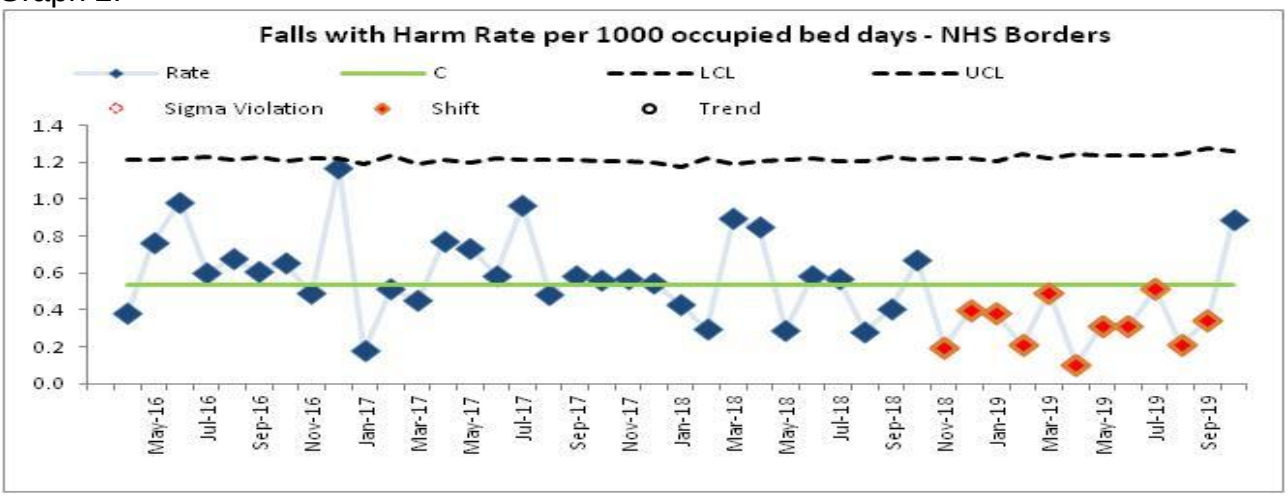
NHS Borders rate of falls per 1000 occupied bed days has remained constant and within normal limits as outlined in Graph 1 below.

Graph 1:



The rate of falls per 100 occupied bed days which result in harm has shown a positive downward shift between November 2019 and September 2019. As outlined above work is underway to roll out the best practice introduced in the Medical Assessment Unit to other clinical areas.

Graph 2:

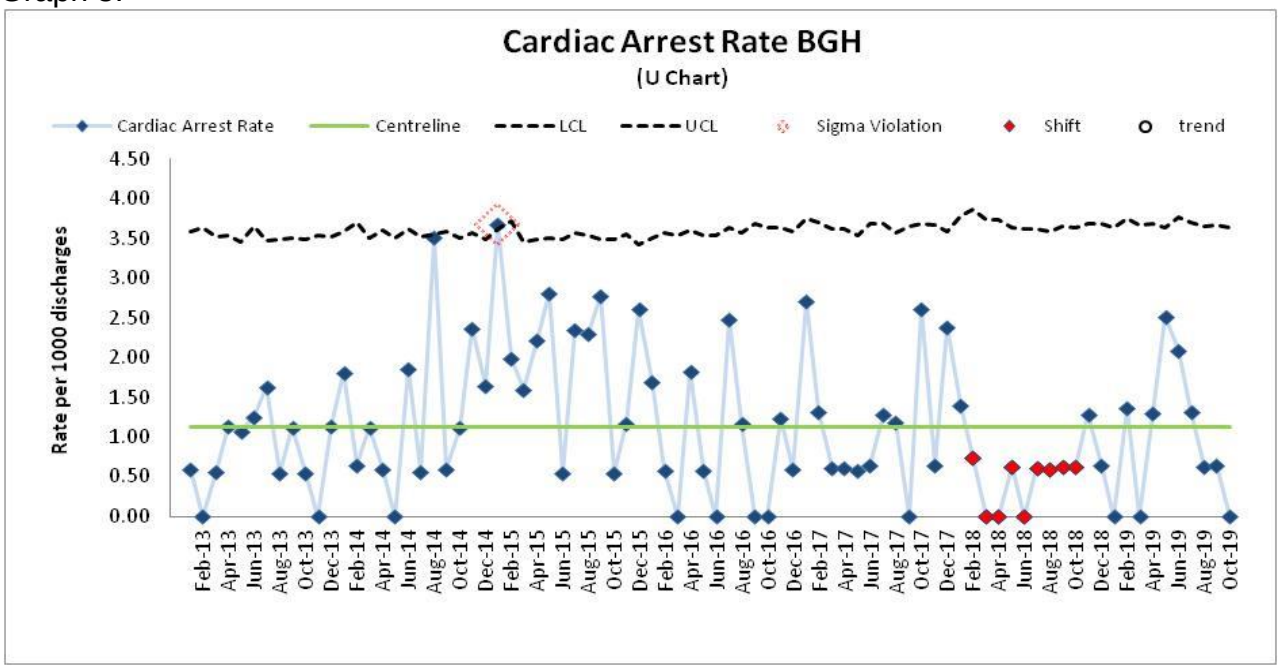


Deteriorating Patients

NHS Borders are planning a move over to the National Early Warning Score 2 (NEWS2) system and documentation from NEWS1 currently in use across all inpatient areas for the management of deterioration. This will be rolled out in conjunction with a new document for recording fluid management in line with the National Intravenous Fluids (IV) programme. A robust education plan will support the introduction of these new documents to ensure appropriate support for staffing and a safe transition.

The safety programme tracks cardiac arrests as one measure which can signal the effectiveness of local systems for the recognition and management of the deteriorating patient. A deep dive into cardiac arrests for the last year is currently being undertaken to review any learning and identify areas for ongoing improvement. The last deep dive took place in 2015 and informed priorities for the deteriorating patient workstream at that time. Graph 3 outlines the cardiac arrest rate for NHS Borders showing normal variation.

Graph 3:



Food, Fluid and Nutrition (FFN)

As part of the National IV Fluids programme NHS Borders have appointed a Quality Improvement Nursing Lead for Fluid Management. The postholder will focus on improving practice around fluid management as key priority of the local safety programme. To gain a deep understanding of current practice a 'deep dive' audit has been undertaken to look at current fluid prescribing within the BGH. This took into account information transcribed onto fluid prescription charts, patient identification, the recording of the patient's weight and the type and rate of fluids administered. Whether the fluid prescription correlated with National Guidelines was also considered and how fluid intake and output affected the patient's treatment and their length of stay in hospital. Information used to identify whether a person's condition deteriorated during their stay included analysis of Acute Kidney Injury (AKI) data received retrospectively from NHS Borders Area Laboratory. The 'deep dive' also reviewed data on fluids purchased (for subcutaneous or intravenous infusion) and how they are stored and utilised within the BGH.

The Nursing Lead is now in the process of consolidating the information gathered and has shared a report on the outcomes and priorities with the Back to Basics Group for approval of next steps. A key priority will be the introduction of improved documentation and a Daily Adult Intravenous/Subcutaneous Fluid Prescription Chart Fluid has been designed and produced for local implementation. This will bring greater consistency with the national approach and documentation introduced in other NHS Boards. For staff such as Junior Doctors who move between NHS Boards this will bring greater consistency and less potential for error.

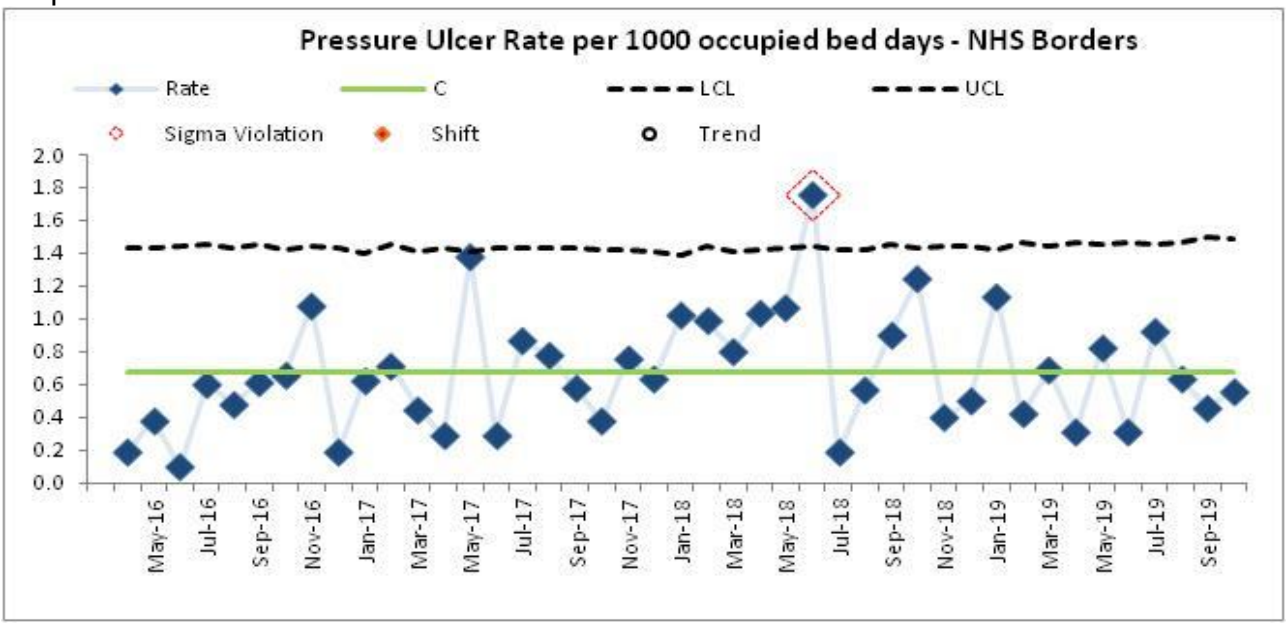
A Standard Operating Procedure (SOP) has been prepared for the checking of menu cards in inpatient areas within BGH. This is one of many steps that have been taken to ensure the safe provision of meals to patients. The SOP, now approved, will be introduced into wards over the coming weeks supported by ward FFN link nurses and senior charge nurses.

In addition, there is a continued focus on achieving NHB Borders' aim of improving the Accurate Assessment, Appropriate Referral and Regular Review of all inpatients at risk of malnutrition on admission or during their stay within NHS Borders. This includes accurate and consistent completion of the Malnutrition Universal Screening Tool (MUST). Toolbox talks are being prepared for delivery to nursing staff and healthcare support workers.

Pressure Damage

Graph 4 outlines the rate of pressure damage across NHS Borders. This remains a priority focus of the Back to Basics programme and a number of initiatives are underway being led by the Tissue Viability Nurse.

Graph 4:



Extensive education support is being provided to clinical teams in this area. A large number of staff, 319, have attended a one hour training sessions on risk assessment, wound grading and the new SSKIN Bundle. A further 78 members of staff from both the acute and community setting have attended the Back to Basics Study Day covering pressure ulcer prevention, risk assessment, wound grading, documentation and dressing selection. A monthly newsletter has been introduced to provide frontline staff with regular information on educational events, equipment and product changes, wound care information, developed pressure ulcer update, dates for Link Nurse 1:1 ward sessions and learning from areas achieving 'Zero Heroes' status. 'Zero Hero' Pressure Ulcer Prevention Information Leaflets have been launched for both the acute and community settings and the Tissue Viability Microsite has been updated with all current documentation and guidance.

Three areas achieved 'Zero Hero' status in November 2019. BGH Ward 9 achieved 5 months free from developed pressure ulcers, BGH Ward 12 achieved 6 months free and Melburn Lodge 10 months free. Cauldshiels ward would have been 365 days free in November 2019.

Maternity and Children Quality Improvement Collaborative (MCQIC)

HIS visited the BGH in August 2019 to meet with the maternity, neonatal and paediatric services teams responsible for leading the local safety programme in these areas. A self-assessment of local progress against the priorities of the Paediatric workstream has been undertaken. The self-assessment identifies difficulties in moving forward the workstream and a local meeting has been planned to identify the barriers to this with the aim of addressing this and making progress in this area.

World Patient Safety Day

An engagement exercise took place in September 2019 to mark World Patient Safety Day that provided patients, visitors and staff across NHS Borders with an opportunity to provide feedback. The event was supported by a member from the Public Reference Group who volunteered to come along and help on the day.

Two simple questions were asked, "what makes you feel safe in hospital?' and "what makes you feel unsafe in hospital?". Comments were received by face-to-face exchanges

in the foyer of BGH and also by sending out cards to inpatient areas in the community and across mental health services that were then returned to the Patient Safety Team. The feedback was collated and sorted into themes and is illustrated on the infographic included with this paper.

It is acknowledged that the survey included relatively small numbers of responses, a total of 143. However, there were positive messages to be taken form the survey, in particular from the patient and visitor group of respondents, whereby more than 50% of people stated that 'nothing' made them feel unsafe in hospital.

In terms of identifying areas for improvement some issues identified around the environmental aspects of personal safety may be easily addressed. Some staff spoke about spillages being left unattended, doors being left open that should be locked and rattling lifts. The findings from the survey will now be shared widely across the organisation over the coming weeks so that teams can consider how the feedback will be used to inform future quality improvement work.

On the day of the event, people passing by the stand were asked to talk to us about 'why safety matters to them'. A social media card provided by HIS was used, adapted and added to a whiteboard to enable staff to write their comments on. All consented to be photographed and for their images to be shared on Twitter @NHS Borders and also using the #SPSP and #WorldPateintSafetyDay hashtags so that NHS Borders' contribution to World Patient Safety Day was shared more widely. The feedback to this question are summarised in the poster also included with this paper.

Adverse Events

Following the completion of the evaluation document relating to NHS Borders' management of adverse events, which was submitted to HIS earlier this year, work has been underway to address any gaps that were identified.

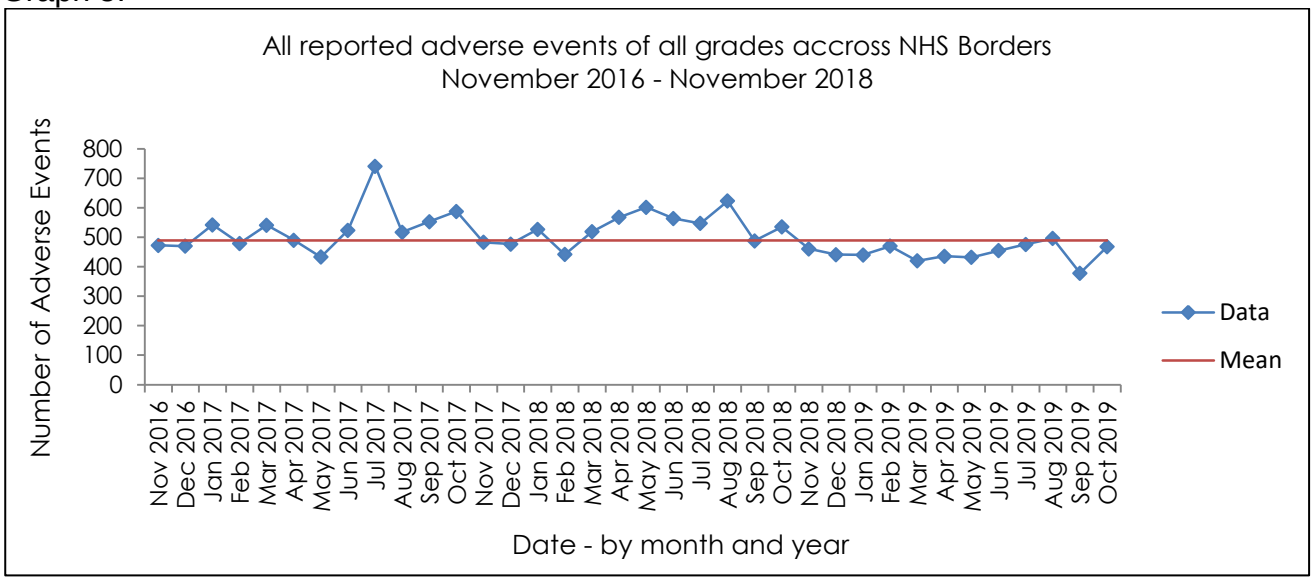
The Clinical Governance and Quality Team have been engaging with HIS in relation to their plan to introduce a national notification system for category 1 adverse events having a level 1 Significant Adverse Event Review (SAER). New arrangements are to be put in place by December 2020 after agreement has been reached on the specific data that is to be reported and the method by which NHS Boards will submit data to HIS.

Work is underway to review the local Adverse Event Management Policy. This will ensure the local policy reflects key learning from the recently published HIS document "Learning from Adverse Events through Reporting and Review, A National Framework for Scotland" and also incorporates requirements under the organisational Duty of Candour (DoC) legislation. A guidance document for the completion of all SAERs has been drafted and includes a toolkit of templates and leaflets to guide and support staff, patients and families through the significant adverse event review process. These templates now prompt staff to consider if the DoC applies and guides them through the appropriate action to take. A training programme will be offered to all potential reviewers once these documents have been approved. In addition, in response to a recommendation from HIS NHS Borders plan to routinely request patients, families/carers and staff feedback on their experience of the SAER process so that continual improvements can be made.

Graph 5 below shows a count of all reported actual adverse events of all grades (including near misses) for all areas of NHS Borders for the last three years. There has been a

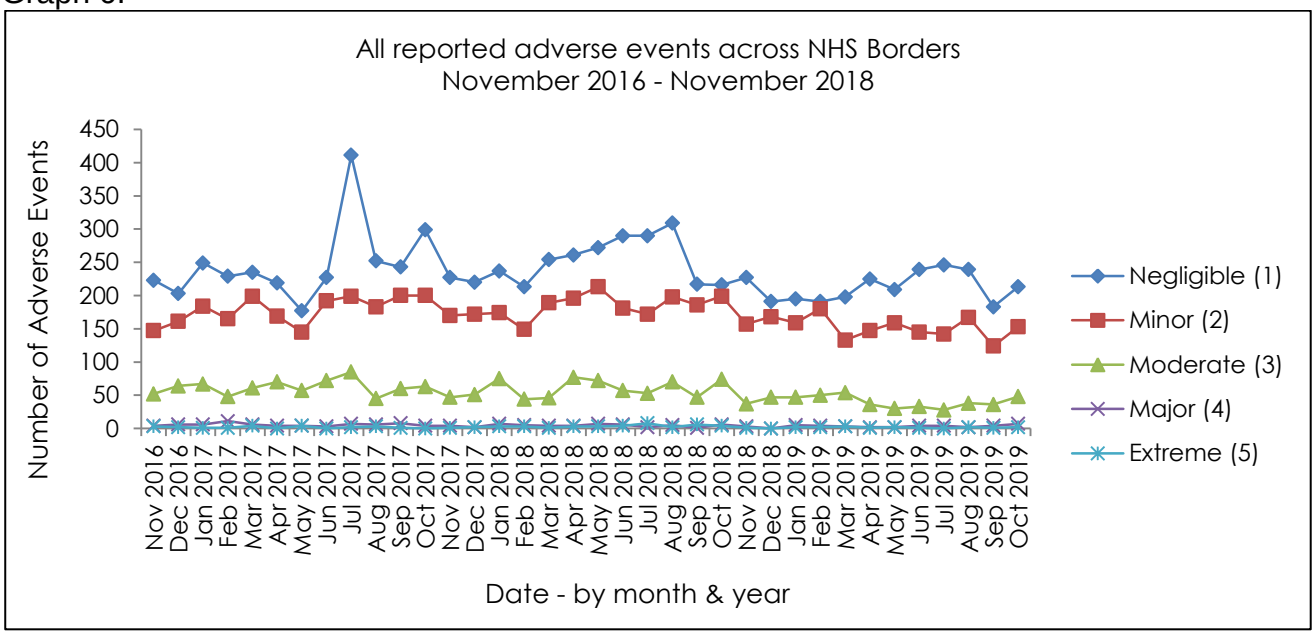
downward trend during the last 12 months which primarily relates to changes in the reporting of laundry events.

Graph 5:



Graph 6 below shows the same adverse events over time broken down by the outcome grading of the event.

Graph 6:



Below Table 1 offers a breakdown of the numbers of adverse events graded with major and extreme outcomes. All major and extremes are referred to by HIS as category 1 SAEs.

Table 1:

Significant Adverse Events (as reported on Datix)						
	2017		2018		2019	
Month	Major	Extreme	Major	Extreme	Major	Extreme
Jan	6	1	7	3	5	2
Feb	11	1	5	3	4	2
March	6	4	4	1	3	3
April	4	0	4	3	2	1
May	4	4	7	3	2	2
June	3	0	6	4	4	1
July	7	2	2	8	4	0
Aug	6	3	5	2	2	2
Sept	8	1	1	6	4	1
Oct	4	0	6	4	7	2
Nov	4	1	3	1		
Dec	2	2	0	0		
Totals	65	19	50	36	37	16

Weekly updates on all Significant Adverse Events (SAEs) graded major and extreme are sent by email to all senior managers that include: The Director of Nursing, Midwifery and Acute Services, The Medical Director, Associate Directors of Nursing (and Midwifery), Associate Medical Directors, Hospital Managers and Clinical Nurse and Service Managers. This highlights the levels of review for each SAE and those where decisions are required to be made. It also provides a brief update on each review in progress at that time.

All completed reviews have a linked improvement plan that is held on the electronic Learning and Improvement Tracker for the relevant service.

CLINICAL EFFECTIVENESS

Inspection

From 25 November 2019 the Care Inspectorate are undertaking a Joint Inspection of Adult Health and Social Care Services: Progress Review. This is a follow-up of the 2017 inspection, reviewing the progress made by the Health and Social Care Partnership against the 13 recommendations made at that time.

An announced inspection on Ionising Radiation (Medical Exposure) Regulations IR(ME)R was undertaken between the 4-5 November 2019 with a focus on diagnostics, particularly plain films and CT. The full report following the visit will be published on Wednesday 29 January 2020. There will be an opportunity for NHS to check draft report for factual accuracy and comment in December. The Healthcare Improvement Scotland inspection team fed back to the Organisation that the visit had gone well and the radiology team were very supportive and helpful.

Excellence in Care

NHS Borders is actively engaging with the national Excellence in Care (EiC) programme. A key element of the programme is the role out of the Care Assurance Information Resource (CAIR) across NHS Scotland which will have consistent measurement of clinical indicators across NHS Boards. CAIR is live within NHS Boards and quality and safety measures for adult and paediatric inpatient areas are now reported through the tool.

Development work is underway to define measures for other nursing and midwifery families within the community with the aim to bring them on Board throughout 2020. Work is underway locally to try and automate data capture and make local data collection as easy as possible for frontline staff.

Dementia Demonstrators
NHS Borders has chosen three clinical areas to participate in the newly launched Dementia in Hospitals Collaborative. The aim of the collaborative is to test and spread improvements in hospital care for people with dementia. This will support the implementation of commitment 7 of the third National Dementia Strategy. The collaborative will run to 2021 with the support of HIS and the Scottish Executive Nurse Directors (SEND) group and Alzheimer Scotland's Dementia Nurse Consultants (ASDNC). It will be delivered using a Breakthrough Series Collaborative approach consisting of a series of learning events, coaching and improvement support for participating teams. One BGH DME Ward, Melburn Lodge and one Community Hospitals have been accepted to participate in the collaborative.

Clinical Audit
The Scottish Hip Fracture Pathway report was published in August 2019. Of the 12 standards measured The BGH continued to be comparative to other hospitals across Scotland. A deep dive was carried out into readmissions on the back of the report as an indicator where NHS Borders was identified as an outlier at 14.6%. Case notes were reviewed by a senior clinician to look at the reason for readmission and whether or not it was felt this could have been avoided if alternative steps had been taken. The outcomes will inform local improvement work.

RESEARCH AND INNOVATION

Research Governance
Since appointment of research governance manager following a nine month gap in post, the focus has been on ensuring that core research governance systems remain robust and contemporary. A new approval system is currently being trialled following national changes to the way research applications are submitted for local approval. Another national process change has involved recruitment upload becoming the responsibility of local sites. Work has been completed to ensure all recruitment and study activity data from the reporting period September 2018 to October 2019 has been uploaded on the national research and development system. This data is used for the annual activity and expenditure reports to the Chief Scientists Office (CSO). The information will determine the CSO allocation to NHS Borders for 2020/21 which is calculated on a three year rolling average.

Innovation
NHS Borders is partnered with NHS Lothian and NHS Fife as part of the East Region Innovation test bed. Work is currently underway to develop a section as part of the Edinburgh Bioquarter website that will give an international reach and provide opportunities to partner with businesses to deliver innovative approaches to the delivery of healthcare.

Research and Innovation Strategy
A new research and innovation strategy for NHS Borders is being developed and a draft will be presented to the Research Governance Committee for comment in December 2019. This strategy will set out NHS Borders commitments and ambitions for the growth of

research and innovation in support of the delivery of safe, clinical effective, person centred and sustainable local services.

In support of the delivery of the local strategy the Research Governance Manager is working to build relationships with key partners. Key partners include NHS Lothian as our nodal partner, the NHS Research Scotland (NRS) networks and specialty group members, the Dunfermline Group (who represent small NHS Boards), clinical research organisations and academic institutions.

PERSON-CENTRED HEALTH AND CARE

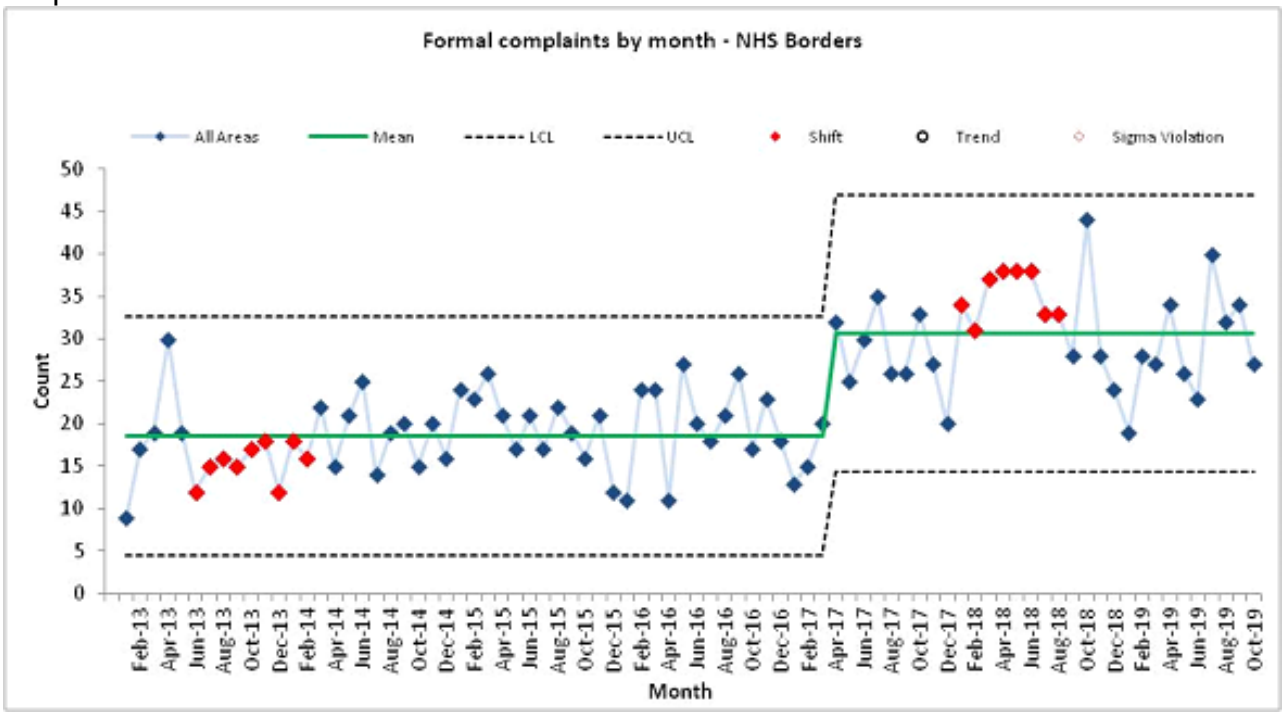
Patient Experience

In addition to formal complaints, feedback is obtained through multiple routes including Care Opinion, the 2 minutes of your time feedback questions placed across NHS Borders sites, through patient feedback volunteers who visit services and talk to patients and their families, through specific service questionnaires, commendations delivered to services and through the Scottish Public Service Ombudsman (SPSO).

Formal complaints

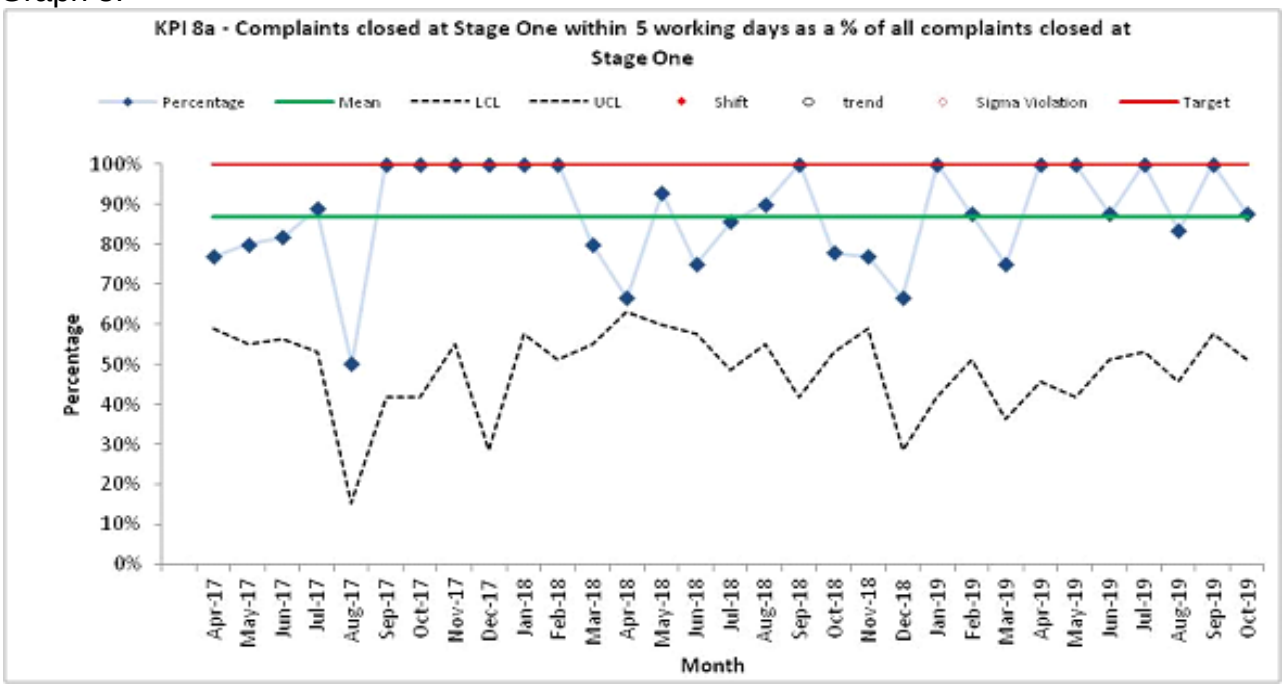
Graph 7 below details the number of complaints NHS Borders received between February 2013 and October 2019. This shows a sustained increase since the introduction of the new complaints handling system in the number of complaints received and has resulted in a recalculation of the UCL, LCL and mean.

Graph 7:



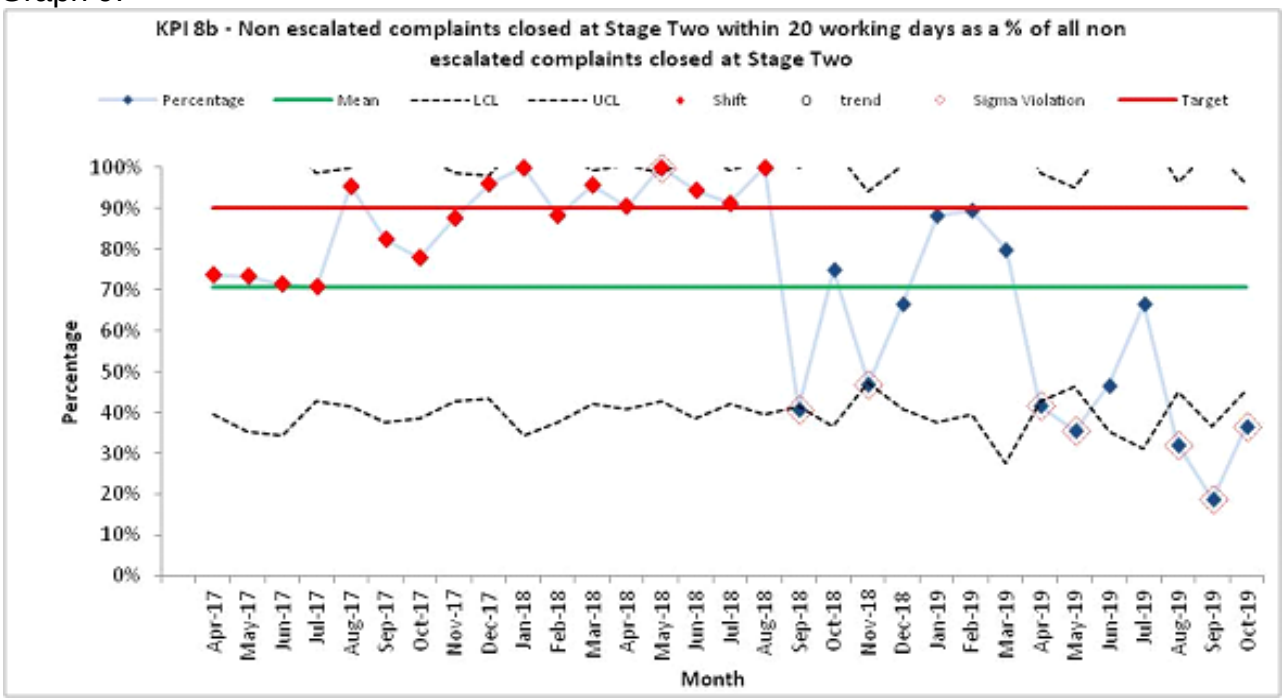
NHS Borders 5 working day response rate for Stage 1 complaints from April 2017 to October 2019 is shown in Graph 8 below. Recent performance has been less variable with an average of 88% of stage 1 complaints being closed within 5 working days.

Graph 8:



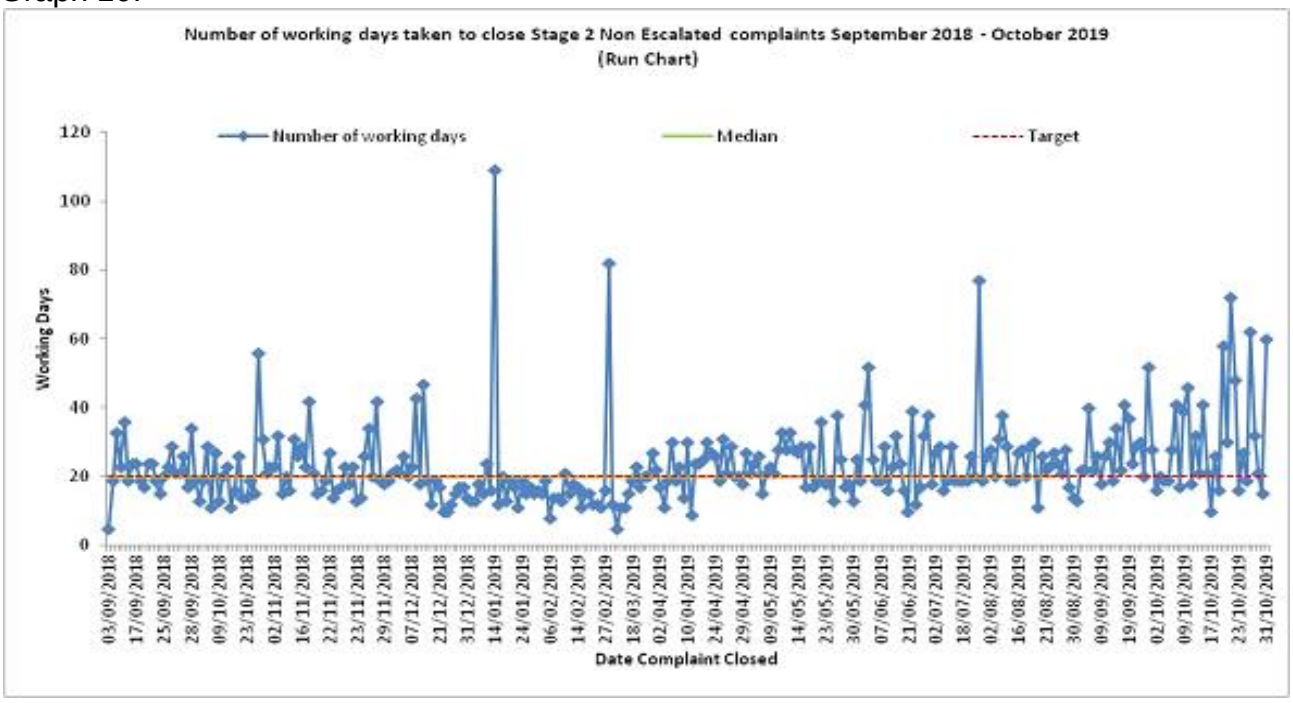
Performance against the 20 working day target for Stage 2 non escalated complaints continues to be variable and below target as set out in Graph 9 below. The Patient Experience Team are now struggling to manage the volume of patient feedback within the timescales expected. This is being reviewed as part of an assessment of workload within the Clinical Governance and Quality function and solutions will be sought through this process to address capacity to enable the team to meet timescales again.

Graph 9:



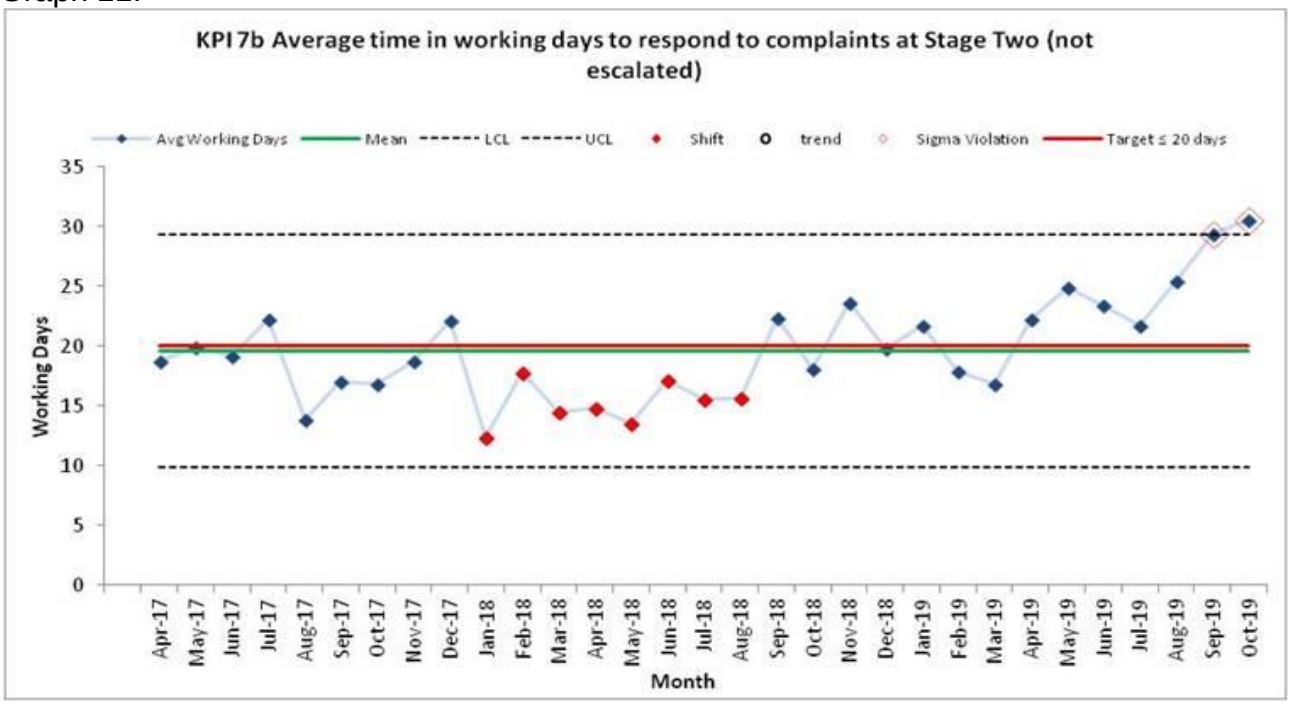
Graph 10 below shows the number of days taken to respond to complaints received between September 2018 and October 2019. The average response time between September 2018 and October 2019 was 23 days.

Graph 10:



Graph 11 below shows that there has been an increase in the average time taken to respond to Stage two (not escalated) complaints. The upper control limit (UCL) has been breached for two consecutive months indicating something has changed in the process. These breaches can be attributed to the fact that, as shown in Graph 10 above, there were several complaint responses closed during September and October that were overdue.

Graph 11:

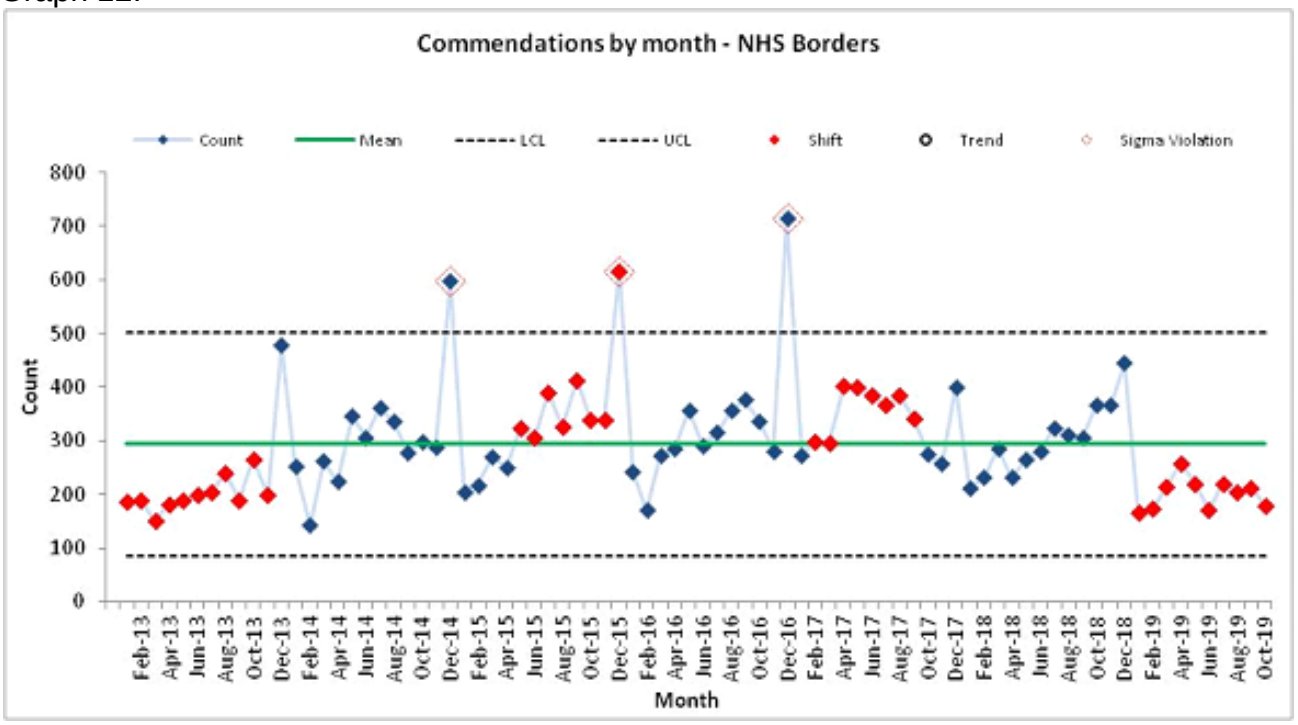


Commendations

Graph 12 below shows that the reduction in the number of commendations being logged by the Patient Experience Team has continued to decrease. It is unclear if this decrease

relates to a change in staff reporting this information, therefore work is underway to raise awareness of the reporting route for commendations.

Graph 12:



Care Opinion

Between April and October 2019 there have been 52 stories about NHS Borders shared on Care Opinion with 77 responses which have been viewed 6,110 times as outlined in Graph 13.

Graph 13:

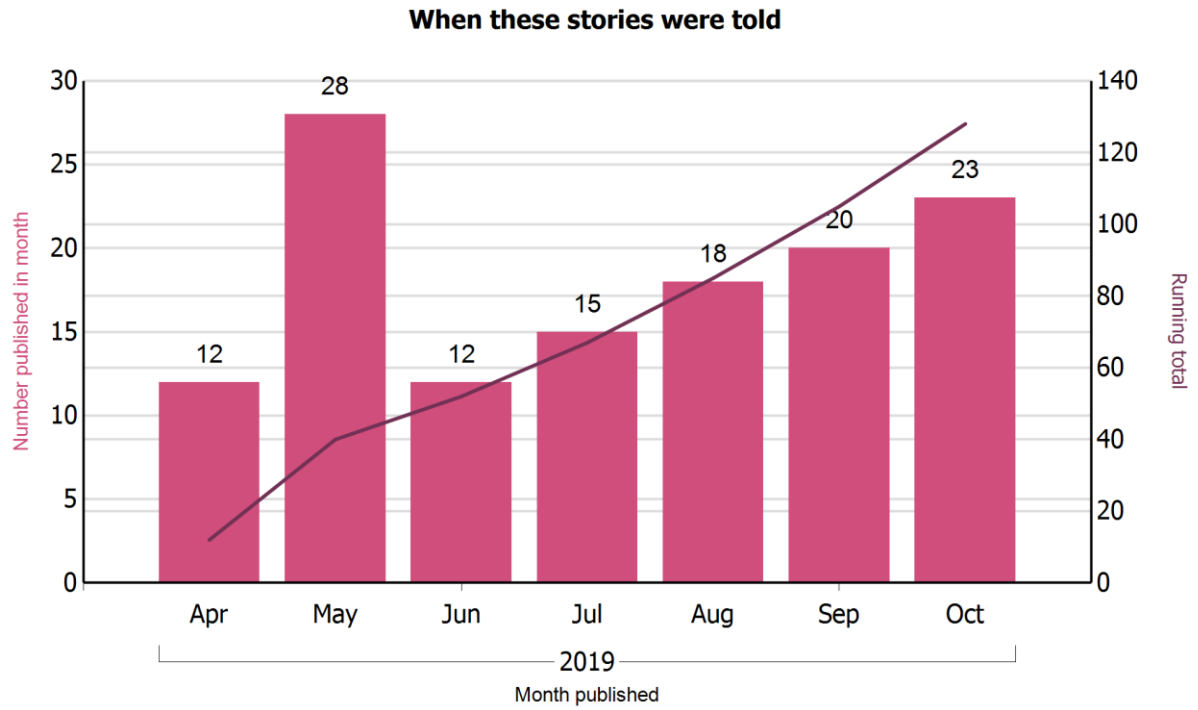


Table 2 provides a summary of Care Opinion feedback for 19 September to 31 October 2019. For the period April to October 2019 78% of feedback on Care Opinion was positive.

Table 2:

Story Title	**Criticality**	**Action (where appropriate)**	**Clinical Board**	**Service**
Excellent care	Positive		Mental Health	East/West Community Mental Health Team
My 97yr old mother's Hospital stay.	Negative	Story highlighted to relevant services and changes made with the aim of achieving effective discharges consistently.	PCS/ BGH	Kelso Hospital Department of Medicine for Elderly (Wards10 & 12)
How well treated l've been during my stay	Positive		BGH	Accident & Emergency Acute Assessment Unit
Every single staff member was nothing but brilliant	Positive		BGH	General Medicine
The wonderful care my Grand-daughter received	Positive		BGH/ PCS	Ear, Nose & Throat Accident & Emergency GP Out of Hours (BECS)
Hospital admission with heart attack	Positive		BGH	Accident & Emergency Cardiology
I am thrilled with the care and attention given to me	Positive		PCS	Physiotherapy
All staff were smiling and kind	Positive		BGH	Accident & Emergency
Birth and Aftercare	Positive		BGH	Paediatrics (Ward 15) Maternity care (Ward 17)
What a special team you are	Positive		PCS	Knoll Hospital
Varying care for my mum	Positive & Negative	Story highlighted to relevant area	BGH	General Surgery (Ward 7) ITU Planned Surgical Admissions Unit Pre-Operative Assessment Clinic
Ongoing care for ulcerative colitis	Positive		BGH	Endoscopy General Medicine Gastroenterology

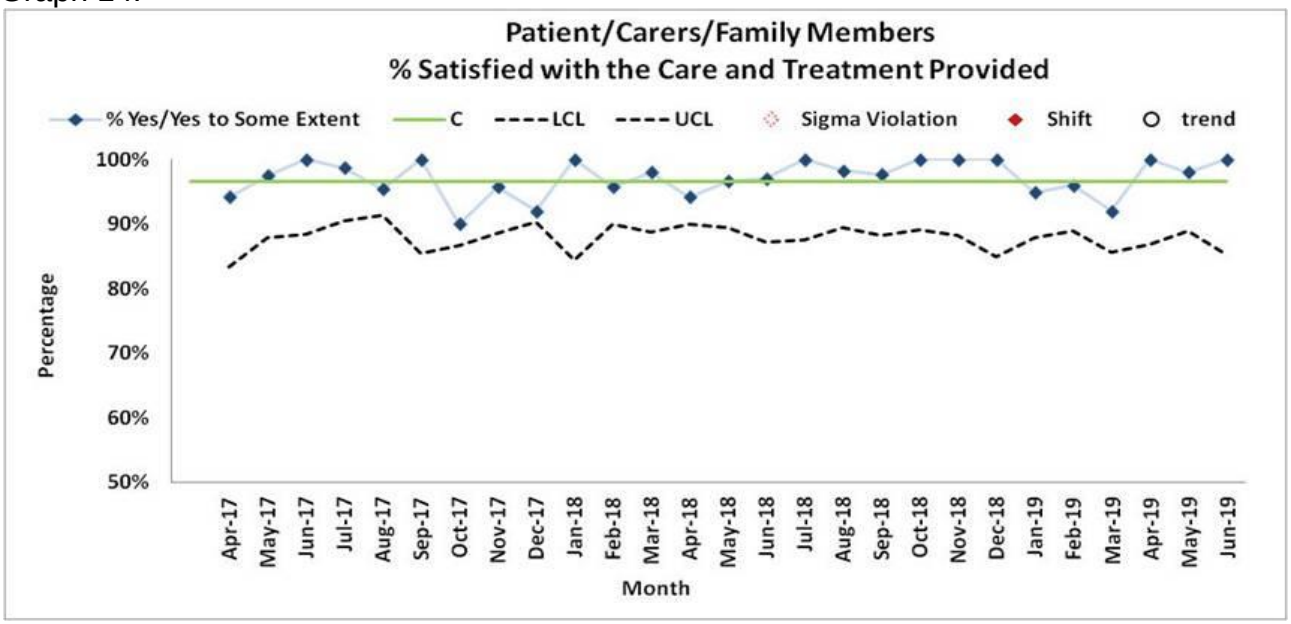
The best treatment from a caring staff	Positive		BGH	General Medicine
Outpatients visit	Positive		BGH	Gynaecology (Ward 16)
Attitude of certain member of staff	Negative	Story highlighted to relevant area	BGH	Day Hospital
Support	Positive		BGH	Occupational Therapy
Our daughters Journey	Positive		BGH	Accident & Emergency Maternity care (Ward 17)
The flagship for mental health service	Positive		Mental Health	Huntlyburn House
Disappointed	Negative	Story highlighted to relevant area. Response posted re appointment arrangements.	PCS	Podiatry
Making funny, googly eye glasses	Positive		BGH	Paediatrics (Ward 15)
Cared for with great compassion and empathy	Positive		BGH	Margaret Kerr Unit

Patient Feedback – 3 Key Questions

NHS Borders continue to use the, 'Two Minutes of Your Time' feedback questionnaire to gather anonymous patient, carer and visitor feedback. In addition, local patient feedback volunteers gather feedback from patients, carers and relatives. There are three key questions which are consistent in both means of gathering feedback. The response for these 3 key questions for the period April 2017 and June 2019 is detailed below:

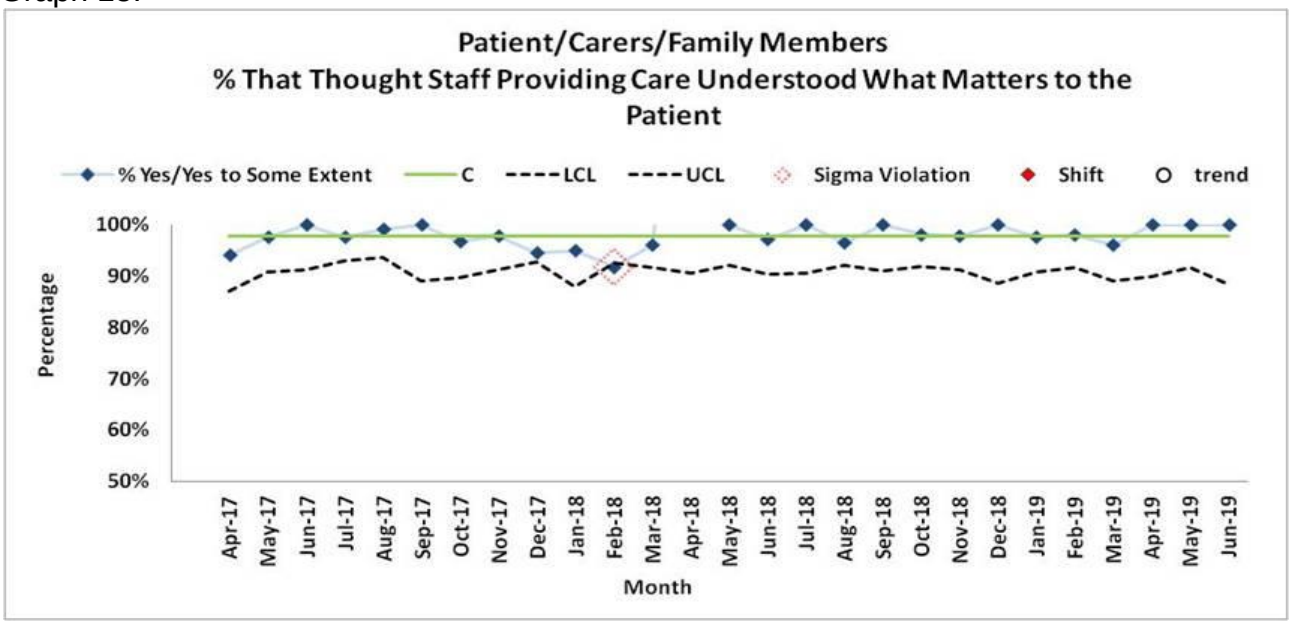
Graph 14 highlights that of those responses received an average of 97% of patients/carers/family members were satisfied with the care and treatment provided.

Graph 14:



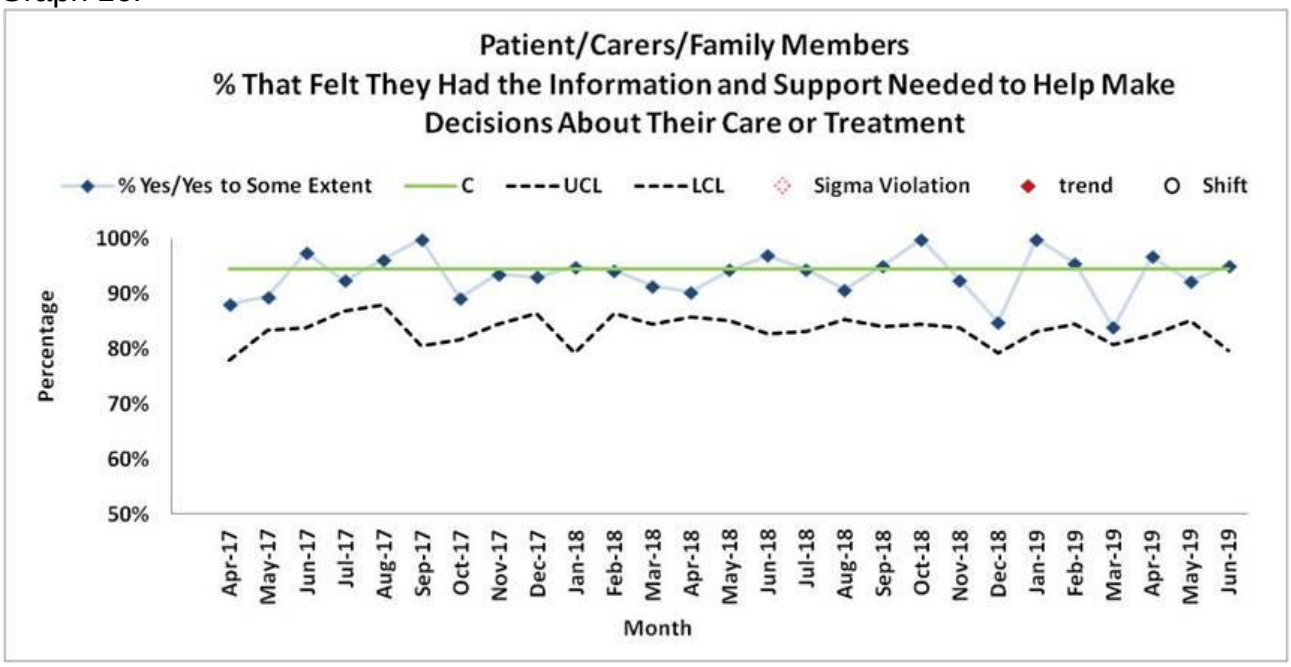
Graph 15 highlights that of those responses received an average of 98% of patients/carers/family members thought that staff providing care understood what mattered to the patients.

Graph 15:



Graph 16 highlights that of those responses received an average of 95% of patients/carers/family members felt they had the information and support needed to help make decisions about their care and treatment.

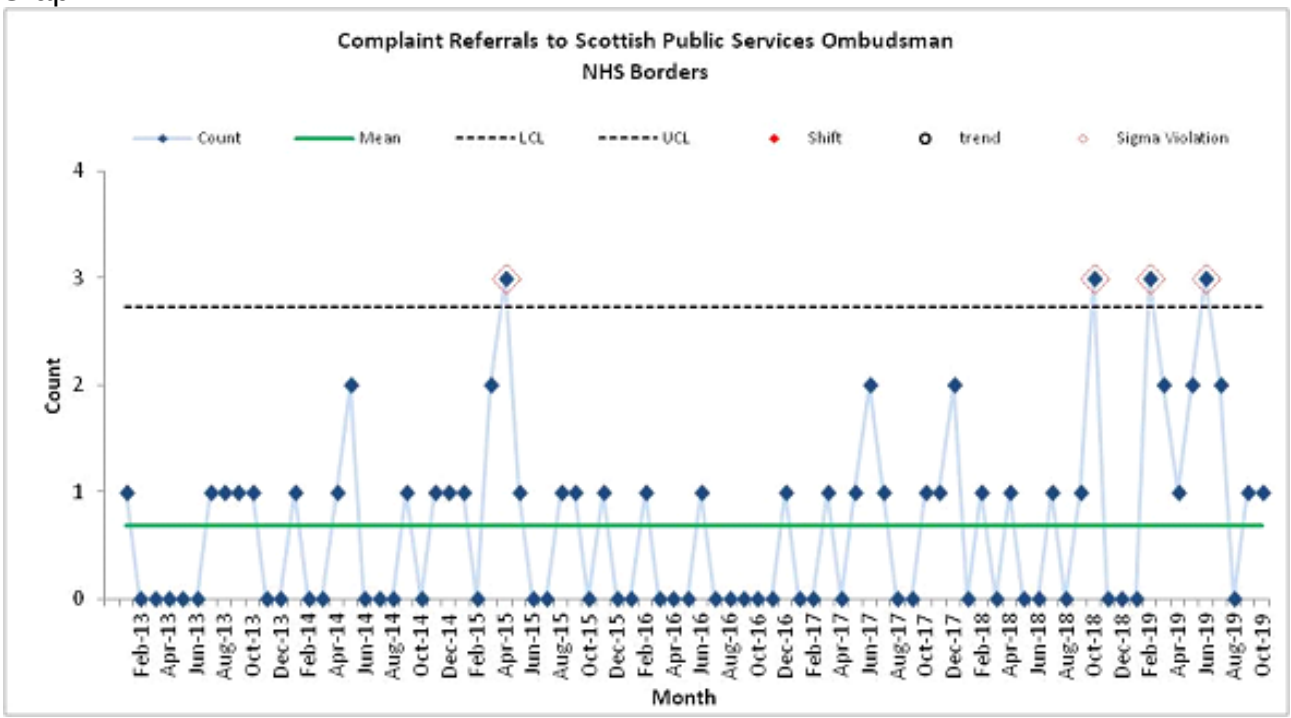
Graph 16:



Scottish Public Services Ombudsman (SPSO)

Graph 17 below outlines the numbers of complaints which have been referred to the SPSO between January 2013 and October 2019.

Graph 17:



During October the SPSO issued their annual letter, which includes statistics relating to NHS Borders cases they handled in 2018-19. The SPSO investigated seven cases relating to NHS Borders, four cases were upheld with fourteen recommendations made. All recommendations were implemented and confirmation received from the SPSO that the actions taken met their recommendations.

Currently there are nine open cases with the SPSO. Information on new cases and decisions from the SPSO and any resulting actions are reported to the Board CGC at each meeting.

Public Involvement

Public involvement work has centred on defining the levels of public engagement required for the various projects within the NHS Borders Turnaround programme. A meeting was held with the Scottish Health Council (SHC) several weeks ago to help identify the requirements and to discuss best ways to approach the involvement which will be required.

As part of NHS Borders Internal Audit programme, Grant Thornton is undertaking an audit of NHS Borders approach to patient and public engagement. The audit will consider the design and operating effectiveness of NHS Borders approach as well as considering future plans. The process has involved interviews with staff; a review of supporting documentation; sample testing of recent patient and public engagement exercises and evaluation; review stakeholder mapping and consideration of how outcomes are captured and evaluated to identify lessons learned. The final report is due to be issued on 3 December 2019 and will be discussed by the Audit Committee on 12 December 2019.

Volunteering

End of Life Care Programme

NHS Borders has been successful in their application to Helpforce, working in partnership with Marie Curie, for funding for the amount of £31,600 for the above programme. NHS Borders will be focusing on the 'Companion Volunteers' model. Volunteers will be recruited and trained to predominately support patients, families and carers in end of life care. The project will be managed by the Quality Improvement Facilitator for Palliative Care and day to day management and support of the volunteers will be provided by a Project Support Officer. The Project Support Officer is a fixed term post funded through the grant received for the programme. The Project Support Officer will form part of the Palliative Care Hub. The Voluntary Services Manager will add guidance, insight and support to the Palliative Care Team throughout the 18 month programme to support the management of volunteers in line with NHS Borders policy and ensure key milestones are met.

Volunteering Policy

NHS Borders Volunteering Policy is due for review. The Voluntary Services Manager has circulated a draft copy of the policy to the Volunteering Steering Group members and Volunteer Leads for comment prior to the policy being taken to the Clinical Executive Strategy Group for approval.

World Patient Safety Day 17 September 2019

81 Staff responses across NHS Borders

62 Patients and Visitors responded across NHS Borders in-patient areas

We asked staff
What makes you feel **safe** in hospital?

Did you know?

44%

of the 43 respondents said COLLEAGUES - listening and support

- 15% Resources - having enough staff
- 9% Training & Equipment
- 15% Systems, processes & procedures
- 7% Safety & Security
- 4% Nurse/Manager in Charge
- 4% Working in own clinical area

We asked patients and visitors
What makes you feel **safe** in hospital?

Did you know?

40%

of the 32 respondents said CARE, ATTENTION KINDNESS FRIENDLINESS & RESPECTFULNESS of staff

- 22% Professionalism, knowledge & competence of staff
- 22% Safety & Security
- 19% Staffing levels & continuity
- 13% Communication & Consultation

We asked staff
What makes you feel **unsafe** in hospital?

Did you know?

42%

of the 38 respondents said A LACK OF RESOURCES - not having enough staff

- 3% Financial Constraints
- 13% Patients & visitors - aggression & violence
- 11% Environmental Issues
- 11% Staff attitudes & behaviours
- 8% Lack of nursing or medical support
- 8% Safety & security - including ward closures
- 8% Other organisational safety mechanisms

We asked patients & visitors
What makes you feel **unsafe** in hospital?

Did you know?

53%

of the 30 respondents said NOTHING made them feel unsafe

- 13% Ineffective Communication
- 23% Other Factors
- 7% Busy ward & not enough staff
- 7% Other patients
- 7% Staff not knowing me or understanding my condition
- 3% Being moved from ward to ward

NHS Borders

World Patient Safety Day 17 September 2019

Thank you to everyone who participated

Caroline Wylie

We asked people to come & talk to us, complete a feedback card or write on one of our whiteboards and tell us and WHY SAFETY MATTERS TO THEM.

all photos were posted on Twitter on the day

"I care about making sure our patients get the best care possible..."

"For information to be shared with me and to be listened to"

"Understaffed wards / departments"

"Without it we wouldn't be here"

"I have allergies and I have to make sure all food is safe..."

"Evidenced based treatment options within person centered care"

"It underlines all that we do"

"All patients should be looked after in the right place by skilled staff every day"