Remobilisation Plan 3 – Responding to COVID-19

2021/22

V1

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Glossary

Abbreviation	Meaning
H&SCP	Health & Social Care Partnership
IJB	Integration Joint Board
CICAS	Community Infection Control Advisory Service
SAS	Scottish Ambulance Service
SIP	Strategic Implementation Plan
APF	Area Partnership Forum
ICU	Intensive Care Unit
RPG	Recovery Planning Group
IPCT	Infection Prevention and Control Team
PPE	Personal Protective Equipment
RAG	Red/Amber/Green
CPAP	Continuous Positive Airway Pressure
CV HOU	COVID-19 Higher Observation Unit
MAU	Medical Assessment Unit
MKU	Margaret Kerr Unit
JCVI	Joint Committee on Vaccination and Immunisation
PCIP	Primary Care Improvement Plan
ED	Emergency Department
PCR	Polymerase Chain Reaction
LFD	Lateral Flow Device
MTU	Mobile Testing Unit
KPI	Key Productivity Indictor
GSAU	Gynae Surgery Assessment Unit
AAU	Acute Assessment Unit
AHP	Allied Health Professional
P&CS	Primary and Community Services
GIRFEC	Getting It Right For Every Child
SLT	Speech and Language Therapy
CYP	Children and Young People's Services
CPI	Combined Practice Inspections
PDS	Public Dental Service
CHAC	COVID-19 Hub and Assessment Centre
MIU	Minor Injuries Unit
BUCC	Borders Urgent Care Centre
CCRT	Community Care Home Review Team
CAIR	Care Assurance Information Resource
OPAA	Older Persons Assessment Area
ACRT	Active Clinical Referral Triage
PIR	Post Infection Review
SACT	Safe Delivery of Chemotherapy and Associated Treatments
SCPG	Surgical Clinical Prioritisation Group
PAU	Pregnancy Assessment Unit
RCOG	Royal College of Obstetricians and Gynecologists

RCM	Royal College of Midwives
AUPR	Adult Unitary Patient Record
MDT	Multi-Disciplinary Team
CPN	Community Psychiatric Nurse
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
ND	Neurodevelopment
LACS	The Local Area Co-ordination Service
DCO	Day Centre Office
OSCEs	Observed Structured Clinical Examinations
BAU	Business As Usual
PACE	Policy and Conditions of Employment

Introduction

1. This is the third iteration of an NHS Borders Remobilisation plan, the first being submitted to Scottish Government on 25th May 2020, followed by an updated plan on 31st July 2020. This plan responds to the issues set out in John Connaghan's letter of 14th December 2020 which commissioned the plan and covers the period from April 2021 to March 2022. The plan is in place of the Board's normal Annual Operational Plan.

1.2. It should be noted that this plan outlines our thinking and work to date as at end of February 2021 in order to safely remobilise services in line with the phases as set out in *Remobilise, Recover, Redesign: The Framework for NHS Scotland*[1]. It sets out our underpinning assumptions on finance, workforce, capacity and performance as at the time of writing. Learning from our experiences to date with COVID-19 we recognise we will need to refine our plan as the pandemic progresses and as the COVID-19 vaccination programme is delivered. We recognise that in its current form this plan lacks a detailed action plan to underpin our statement of intent that is laid out in this document. As we emerge from the current wave of COVID-19 and our normal winter pressures our intention is to develop this through our internal governance structure as detailed later, with this being detailed in the next iteration of our plan.

1.3. It is clear from our experience of our initial response, recovery, resurgence and further remobilisation that it will not be possible in all cases to restore services to pre-pandemic levels as long as enhanced public health measures remain in place. It is further evident that what can be delivered from within existing resources (workforce, infrastructure, and finance) is diminished as a result of the additional conditions applicable to 'business as usual'. Even at this level, the requirement to operate core services alongside the additional measures in place to support the pandemic response means there is an immediate and ongoing resource impact.

1.4. Where it has been or is possible to mitigate the reduction to core capacity, or to enhance service provision to address areas of clinical priority, it has been shown these measures come with a further requirement for investment. The constraints on available resources, particularly in relation to workforce and physical infrastructure (IT and buildings), will continue to determine the extent to which this plan is able to be implemented.

1.5. The financial plan for 2021/22 includes assessment of the costs of delivering the actions outlined in this document. Costs estimates remain in draft and reflect uncertainty over the interdependencies and phasing of recovery and remobilisation actions. The plan assumes that RMP3 expenditure will be fully funded; however there remain significant risks around the plan. No assessment has yet been made of the financial resources required to recover performance against Access standards and to address unmet need and the wider impact on public health, including health inequalities and mental health and wellbeing.

[1] *Remobilise, Recover, Redesign: The Framework for NHS Scotland* https://www.gov.scot/publications/re-mobilise-recover-re-design-framework-nhs-scotland/

1.6. Our financial plan demonstrates an increasing recurring deficit. This arises both in relation to increasing cost pressures and due to slippage in delivery of recurring savings, both in 2020/21 and projected ongoing slippage in 2021/22. The board's financial turnaround programme has been suspended throughout the last financial year and the challenge of remobilising this programme with competing priorities around ongoing pandemic response, rollout of COVID-19 vaccination, and remobilisation of services, presents a significant risk to the financial plan.

1.7. Despite this, we are able to present a plan that indicates an in year shortfall in line with previous estimates and we would seek agreement to additional support as previously agreed to enable this gap to be addressed in 2021/22.

1.8. For NHS Borders, the issue of financial resources available to deliver the plan is particularly critical given that the board is currently on *Stage Four* of the Performance Escalation Framework.

1.9. There is real concern that after such a sustained period of intense, physically & emotionally draining work, some staff may be *running on empty* and badly in need of rest & recuperation to get over the travails of the last 12 months. Some professional journals are reporting the risk of post traumatic stress disorder for those staff who have worked on COVID-19 and intensive care wards. Many staff will need time to decompress, reflect and recharge their batteries before a return to all of the pressures that already existed pre-COVID-19. It is therefore essential that time for staff decompression is built into our remobilisation plan and any expectation and targets for this set by Scottish Government.

1.10. Given all of the above, our remobilisation plan for health and care services within the Borders will remain in draft awaiting feedback from Scottish Government and will be refined based on this. The expectation is that the plan will go through board governance and subsequently be published once feedback has been received.

1.11. This one year plan will act as a transition into NHS Borders' longer term plan which is expected to be developed by the latter part of 2021 and will come into force from April 2022 onwards.

Remobilise, Recover, Redesign- The Framework for NHS Scotland

2. Remobilise, Recover, Redesign: The Framework for NHS Scotland was published at the end of May 2020 and sets out how health boards will safely and incrementally prioritise the resumption of some paused services, while maintaining COVID-19 capacity and resilience.

2.2. The Framework sets out a number of assumptions and principles for the safe, effective remobilisation of health services. In developing the first iterations of our Remobilisation plan, NHS Borders agreed a number of underpinning assumptions, conditions, principles and constraints which will underpin and impact on our remobilisation planning. These are

attached in Appendix 1 for information, and are fully consistent with the national assumptions as set out in the Framework.

2.3. These principles are at the heart of our remobilisation planning, as set out in the later sections of this plan.

A Partnership and Whole System Approach

3. Throughout the pandemic NHS Borders has engaged with partners including the Integration Joint Board, the staff in our Health and Social Care Partnership (H&SCP) and Scottish Borders Council colleagues. Joint Executive groups between the Council, NHS Borders and the IJB met daily at the beginning of the pandemic and continue to meet weekly, whilst a range of operational groups continue to deliver services to both mitigate the risk of COVID-19 outbreaks, and to deliver joint services to support vulnerable groups.

3.2. To ensure oversight of care homes and care at home a Strategic Oversight group and an Operational Group were set up across the H&SCP which meets daily with input from the Care Inspectorate.

3.3. NHS Borders Public Health and Infection Control colleagues have been supporting Care Homes and Care at Home. NHS Borders introduced a Community Infection Control Advisory Service (CICAS) at the beginning of the pandemic in order to enhance the level of infection control advice available. This service is made up of staff from Public Health, Infection Control and other staff deployed from their substantive role temporarily into this service. This work has been critical to managing COVID-19 in the community and we are now looking to incorporate these responsibilities into an enhanced infection control team.

3.4. Primary Care services including our GP colleagues have been a particular focus within our response to COVID-19. Resilience meetings have been held and services offered to individual practices from within the partnership where additional needs were identified as a result of COVID-19. Colleagues within the Scottish Ambulance Service (SAS) and NHS24 have supported our response.

3.5. As we once again move to remobilise services our enhanced joint working with Council and IJB colleagues will continue in order to ensure that there are no conflicting plans or any unintended consequences that challenge or cut across our respective services.

3.6. Throughout the pandemic, we have been seeking to capture the lessons of what worked well and what didn't. In the summer of 2020 following the first wave of COVID-19 we commissioned a Collecting Your Voices staff engagement exercise, which provided valuable information that we have used to inform our remobilisation plans. Continued staff engagement through the programme is underway focusing on what one thing would most help at this time. Lessons learned from the initial response phase of the pandemic have been discussed in detail with the senior teams at NHS Borders and Scottish Borders Council and with colleagues on the NHS Borders Board, IJB and members of the Council. As we again return our focus to remobilisation of services this will continue to be a key theme of discussion. In both undertaking and applying the lessons learned as we remobilise, we aim

to work collaboratively with staff and users of services, to be more agile and devolve decision making and ensure a greater sharing of accountability. This will both serve to support us as we address future service challenges as well as to establish a more robust, fair and effective organisation for the future.

3.1 Whole System Working

3.1.1. The Integration Joint Board, in collaboration with NHS Borders and Scottish Borders Council is looking at reshaping and further developing the whole health & care system across the Scottish Borders. During the previous phases of the pandemic, we recognised that there are opportunities in particular to develop services that provide comprehensive support to older people during times of crisis. Reviews of how services have performed for older people in particular during COVID-19 and a detailed evaluation of the intermediate care services funded through the IJB Transformation Programme have identified the need to develop a whole system set of pathways for the support of people who leave hospital and to ensure that no-one stays in an acute hospital setting when it is no longer needed.

3.1.2. The pathways identified are as follows:

- Supporting people who are discharged home with support from the local community and community services
- Supporting people who are discharged home to recover and reable
- Supporting people who require discharge to a bedded facility to recover and reable
- Providing facilities where people can be discharged from hospital to a bedded or homely setting to establish their long term needs

3.1.3. The emerging approach to developing these pathways is to work in collaboration with older people and other stakeholders in each locality within the Borders to create a comprehensive service structure most suited to the needs of each locality. This is an ambitious programme and will take some time to achieve. In the interim, we will actively implement a refocusing of existing services to ensure they more effectively meet the identified needs of older people. This work will be overseen by the Older Peoples Pathway sub-group of the IJB's Strategic Implementation Plan (SIP) programme board.

3.2. Working In Partnership with our Staff

3.2.1. In developing our remobilisation plans we have continued to engage widely with our staff across the organisation. Staff members have been involved in discussions relating to their services and in wider business unit plans through Local Partnership Forum discussions. We have also ensured direct involvement of Partnership Leads and the Employee Director on local remobilisation planning groups across all Business Units and NHS Borders Remobilisation Planning Group. Responding to COVID-19 and now remobilisation of our services are standing agenda items at the Area Partnership Forum with additional briefings arranged in-between formal meetings as required. There have also been specific areas of remobilisation planning discussed at the Area Staffside and accessibility to escalate and engage directly between Staffside (including full time officers) and the Chief Executive and the Director of Workforce facilitated via the Employee Director when required.

High Level Planning

4. Modelling

4.1 Throughout the pandemic we have used modelling and scenario planning to assist services in planning for COVID-19 and non-COVID-19 demand. The core of this process is a daily updated Borders model, projecting the next 3 weeks based on current trends and a small range of agreed scenarios.

4.2. We have constantly reviewed and revised our scenarios based on national modelling updates, local data analysis and early intelligence around likely future trends. This approach has embedded the concept of scenario modelling, with services now comfortable to plan future demand against a range of possible trends, and holding contingency plans for worst case scenarios.

4.3. We are currently developing revised scenarios to model projections for March and April, based around the likely impacts of vaccination and the lifting of lockdown measures. These will be informed by national guidance and past experience and are likely to include scenarios that either assume a continued decline in infections, or a rise in infections due to the lifting of lockdown, with a small peak in April and a status quo scenario. The engagement and sharing of experiences between Boards has been invaluable in supporting this.

4.4. As we move out of the latest COVID-19 surge, we are working with Public Health Scotland and Cap Gemini as a pilot site for the Whole System Model and are increasingly taking a modelling approach to other areas of service across both health and social care, including supporting the remobilisation of our services. We will be reviewing the expertise and resource required to maintain this approach as we move out of the pandemic to aid future service design and service responses.

4.1 Health Inequalities

4.1.1 There has been a groundswell of commitment from within the organisation to ensure we take action to create a more equitable and fairer health services following the pandemic.

4.1.2 The COVID-19 pandemic has highlighted the impact of health inequalities on different communities in the Scottish Borders:

- Teviot and Berwickshire (which have many of the more disadvantaged communities in the Borders) have had the highest proportion of positive cases by population and Cheviot and Eildon the lowest; the Teviot rate was 2.3 times higher than Eildon rate
- 54% of hospital admissions and 70% of deaths were amongst people over the age of 75
- 50% of workplace outbreaks were within health and social care settings

4.1.3 A group of senior stakeholders from all areas of NHS Borders has been meeting to develop a plan to address these inequalities. The focus is on developing practical actions that can be taken at all levels of the organisation and that are evidence-based to improve service delivery for people in groups most affected by health inequalities. A range of actions are

already being taken forward through workforce and public health and this work will build on these.

4.1.4 Actions will be based on the 5 areas identified in the Marmot report and set out within the NHS Health Scotland publication 'Maximising the role of NHSScotland in reducing health inequalities[2]'. These are:

- Quality services with allocation of resources proportionate to need
- Training the workforce to understand their role in reducing inequalities
- Effective partnership with different sectors to help reduce health inequalities
- Mitigation of inequalities through employment and procurement processes
- Advocating to reduce health inequalities

4.1.5 The group is therefore proposing:

- To work with the Health Board to develop a renewed commitment to addressing health inequalities as a corporate priority
- To establish a Health Inequalities Steering Group with senior leadership to provide direction to this work
- To engage with groups and individuals most affected by Health Inequalities, taking a participative and co-production approach to taking action
- To develop approaches to addressing health inequalities at all levels of the organisation from front-line clinical services to Executive and Board level
- To take a Programme approach to developing and rolling out this work, building on our experience with other large-scale change programmes, such as the Scottish Patient Safety Programme
- To establish effective datasets and reporting mechanisms to enable ongoing monitoring and evaluation of the effectiveness of the programme

4.1.6 Close working with Scottish Borders Council and through the Community Planning Partnership is also already underway to support and build on existing work.

4.1.7 A detailed plan and identification of the resources to undertake this is being developed.

4.1.8. Throughout all of this work all partners have been aware of the Human Rights of all of our citizens. COVID-19 has accentuated some of the inequalities within our communities through its disproportionate impact on our more deprived households, those with particular health conditions/disabilities and particular Black Asian and Minority Ethnic communities. This remobilisation plan and the further restructuring and re-commissioning of Health and Social Care Services, will as a result of this pandemic be better placed to collectively tackle these health inequalities within our localities. Discussions are currently underway to consider establishing a Health Inequalities Group within the Health Board. The plan is that this will be a multi-disciplinary group and will consider matters of ensuring fairness & equality between different groups, respect for diversity and encouraging inclusion in service design/delivery, community/staff engagement and employment. In due

[2] http://www.healthscotland.scot/media/2103/strategic-statement-english.pdf

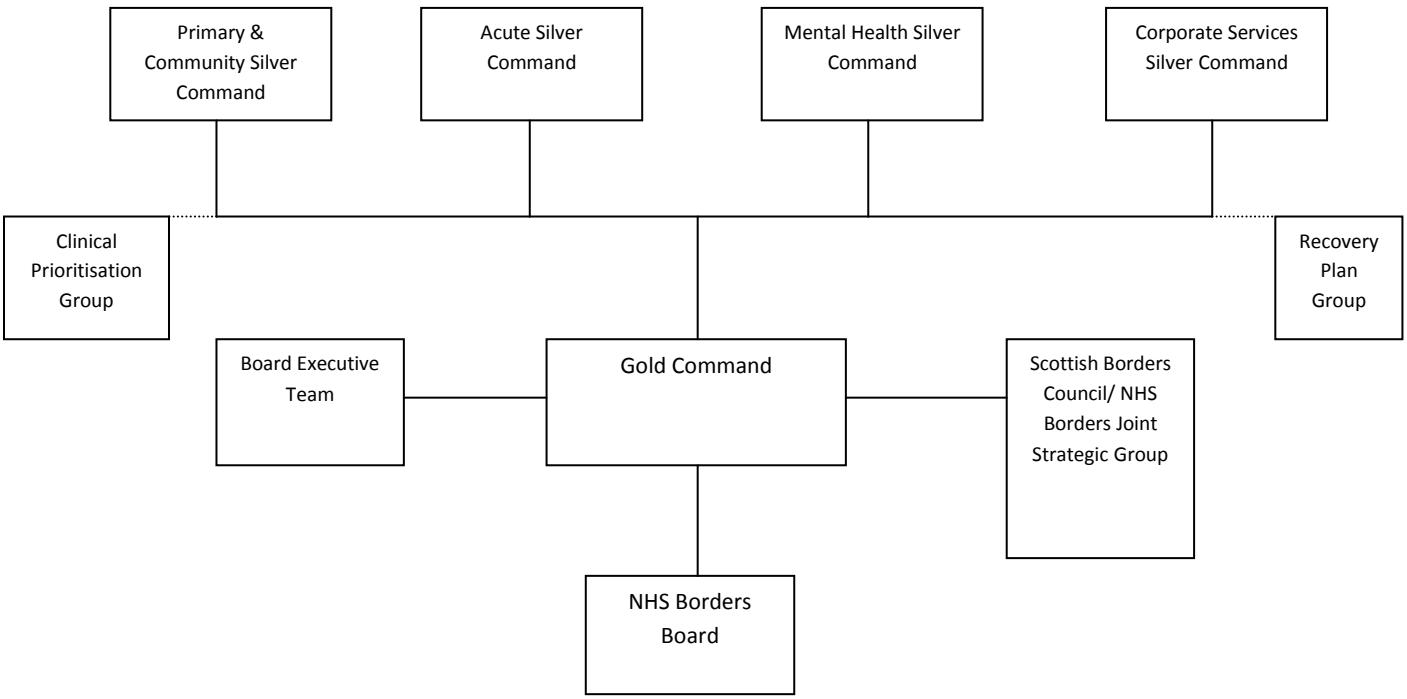
course, this group would develop its strategic goals and desired outcomes which would be performance managed.

Current Position against Key Aspects of Current Remobilisation Plan

5 Prior to NHS Borders seeing resurgence in COVID-19 cases in December 2021 we had been able to remobilise our services to the level set out in our previous remobilisation plan. To support our response to increased COVID-19 related hospital admissions over the last 2 months a decision was taken to pause all routine surgery and face to face routine outpatient activity. As we have now begun to see a reduction in COVID-19 related admissions we have produced a plan to resume these activities, with the anticipated restart of routine activity from the beginning of March 2021. This is dependent on our ability to continue to contract our COVID-19 ward bed base and ICU footprint back to a single unit and reduce the need for surge beds across our medical wards.

Governance Arrangements during the Pandemic

6 The NHS Borders COVID-19 Recovery Plan Group (RPG) was established in April 2020 to co-ordinate the recovery response to the pandemic. This virtual group meets weekly (or more frequently if required) to provide a system wide approach, with representation from all business units (Acute, Primary & Community Services, Mental Health, Learning Disabilities, and Corporate Services). The group also has membership from Adult Social Care and Public Health. The RPG reports to the Board Pandemic Committee (Gold Command) who in turn report to Borders NHS Board. Below is a structure chart that demonstrates the governance structure:



6.2 With the onset of the COVID-19 pandemic, the challenges faced by the NHS, social care and the wider partnership systems required the Board to establish temporary and appropriate governance arrangements. The Board required the organisation to continue to operate within an appropriate legal framework, act in the best interests of the population, be efficient in the use of resources and put the safety of staff and patients at the forefront of its efforts.

6.3. As a result NHS Borders Board agreed in April 2020 to a temporary revision to our corporate governance arrangements. This decision was taken recognising front line staff, senior officers and the Executive Team must be allowed to deal with the COVID-19 Pandemic with as little distraction as possible but whilst still operating within an appropriate governance framework.

6.4. In July 2020 the Board approved a return to normal governance arrangements effective from 1 August 2020. This continues to be the case with some limited adjustments to the frequency of meetings in the 4th quarter of 2020/21 following the recent spike in COVID-19 activity. RPG continues to meet on a weekly basis as we continue to remobilise following the second COVID-19 wave.

6.5. As we move through the pandemic we anticipate standing down the command structure, and as a result will be revisiting our internal decision making processes to ensure they remain fit for purpose post COVID-19.

6.1 Clinical Prioritisation Framework

6.1.1 During the pandemic, we developed a clinical prioritisation framework to ensure that the most significant decisions about allocation of resources were directed by clinical judgement.

6.1.2. The framework comprised:

- A process for reviewing competing service demands in a structured and objective way
- A Clinical Oversight Group comprising the most senior clinicians within the organisation to assess critical allocation of resources and remobilisation of services
- Local clinical prioritisation processes, including an elective surgical prioritisation group

6.1.3. The Clinical Oversight Group is convened as required and has been mobilised to consider three significant areas of decision-making:

- To review remobilisation plans and advise on priorities for maintenance of services
- To review allocation of early-tranche COVID-19 vaccines prior to receiving JCVI guidance
- The group is being reconvened to consider the prioritisation of re-establishing screening services against operational service demands

6.1.4. The Clinical Prioritisation Group informs the work of the Board's remobilisation group and reports to the Board Clinical Governance Group. The NHS Borders COVID-19 Ethical Advice and Support Group also provide an ethical perspective and oversight role to ensure due process.

6.1.5. The Clinical Interface Group, comprising senior clinicians from across primary and secondary care and mental health meets monthly and provides a more regular opportunity to review resurgence, remobilisation and renewal plans and present clinical issues and concerns.

6.1.6. Further work is underway as part of the high-level planning principles we are following to develop a wider framework for clinical engagement across the organisation.

Living with COVID-19

7. COVID-19 Vaccination Programme

7.1. The NHS Borders vaccination programme is following the requirements as set by the Joint Committee on Vaccination and Immunisation (JCVI). Nationally agreed priority groups have been identified and this determines the sequence that will be followed. The principle underlying the sequence has been to prioritise the most vulnerable patients and staff groups based on potential risk.

Cohort	JCVI Priority Groups	Wave
1	Residents in a care home for older adults and their carers	**1**
2	80 years of age and over and frontline health and social care workers	**1**
3	75 years of age and over	**2**
4	70 years of age and over and clinical extremely vulnerable individuals shielding **under** 65 and **over** 65	**2**
5	65 years of age and over	**2**
6	16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality and unpaid carers	**3**
7	60 years of age and over	**3**
8	55 years of age and over	**3**
9	50 years of age and over	**3**

7.1. **Wave 1 (Cohort 1 & 2) 8th December 2020 to 31st January 2021**

7.1.1 Cohort 1 -94% care home residents, 72% care home staff have been vaccinated to date. Work is underway to increase the uptake of vaccine within the care home staffing group.

7.1.2 Cohort 2- 99% of those aged 80 and over have been vaccinated to date, 73% Social care staff and 105% health care staff. N.B. Health care staff uptake greater than cohort total due to significant uptake by number of private healthcare providers (Community Pharmacies, Opticians, and Dentists etc...).

7.1.3 The 2nd dose vaccinations for wave 1 cohorts commence week beginning 15th February 2021.

7.2 **Wave 2 (Cohorts 3, 4 and 5) Monday 1st February to 28th February**

7.2.1. NHS Borders approached this cohort with a mixed model of delivery from both GP's and Health Board clinics. The Scottish Government accelerated wave 2 delivery, requiring us to complete cohorts 3 and 4 by mid February and cohort 5 by the end of February.

7.2.2. We have progressed well through this cohort with completion as of 24th February at 93%.

7.2.3. Cohort 3 – the age 75 – 79 cohort is 99% complete.

7.2.4. Cohort 4 – the 70 – 74 cohort is 95% complete with 99% for the clinically extremely vulnerable cohort N.B some of the patients within the clinically extremely vulnerable category will have been captured in other reporting categories on the national Vaccine Management Tool.

7.2.5. Cohort 5 – the 65 – 69 cohort is 85% complete.

7.3. **Wave 3 (cohorts 6-9)**

7.3.1. This wave is due to commence mid-February, Cohort 6 is broken down into 4 categories:

- 18 – 64 at risk
- 16- 17 at risk
- SSS unpaid Carers
- Self-registration unpaid carers

7.3.2. At present we have been sent cohort (6a 18 – 64) at risk for verification. The remaining cohort 6 population data is yet to be confirmed and scheduled.

7.3.3. NHS Borders have worked alongside Scottish Borders Council to determine clinic location. The five community locations noted below will now be used from wave 3 onwards:

- Gytes Leisure Centre, Peebles
- Hawick Town Hall
- Eyemouth Community Centre
- Queens Leisure Centre, Galashiels
- Springwood Park, Kelso

7.4. **Vaccinator Workforce**

7.4.1. We are continuing to train and appoint vaccinators in preparation for expanding the programme this year in line with the JVCI priority list and timescales.

7.4.2. As at the date of submission we have deployed 139 of our own staff to assist with our vaccination programme. Since January 2021 we have employed 103 new members of staff and have 53 staff pending employment (pre-employment checks in progress). These new staff latter will provide us with a robust and stable vaccination workforce to carry out the mass vaccination programme without impacting on our other services.

7.4.3. As noted above, NHS Borders is confident in its ability to deliver the waves of vaccination in line with the timescales requested by the Scottish Government. Our current project delivery schedule for confirmed cohorts is noted below, however this may change based upon vaccine availability and any amended timescales set out by the Scottish Government.

7.5 **A Sustainable Longer Term Vaccination Programme**

7.5.1. NHS Borders established an Influenza (flu) and COVID-19 Vaccination Programme Board in autumn 2020 and was successful in rapidly developing and implementing the NHS delivery of the flu vaccination programme over Autumn-Winter 2020/21, and starting the COVID-19 vaccination programme.

7.5.2. Our COVID-19 Vaccination Programme has been successful at delivering clinics across the remote and rural Scottish Borders for our oldest population, and rapidly flexing up and down in line with vaccine availability and the Scottish Government steer on uptake targets. We are working in partnership with GP practices on a hybrid NHS / GP model for waves 1 and 2. Wave 3 will be delivered by NHS Borders.

7.5.3. Uptake for flu vaccination as of the 24th January 2021 was high and is enclosed below:

Category	Uptake
Over 65	88.4%
Under 65 at risk	98.5%
Pregnant ladies	63.6%
Primary school age	82.2%
2-5 year olds	43.7%

7.5.4. Our planning assumption is that there will be a high level of uptake of the COVID-19 vaccination across the Scottish Borders and this has already been seen in the over 80's where we are delighted to have achieved 96% uptake. Our expectation is that this level of uptake will be consistent for waves one and two; with uptake levels' reducing as the age demographic reduces in wave three and any further waves. For wave three and four vaccinations will be delivered on a more centralised basis in fewer but larger vaccination centres across the Scottish Borders. These areas have been determined by NHS Borders in partnership with Scottish Borders Council and Military Planners, to consider best coverage to meet the needs of our residents in wave three and four (see above).

7.5.5. In line with the GMS Contract 2018, the Primary Care Improvement Plan (PCIP) and the recent 'Scottish Government and BMA Joint Letter - GMS Contract Update for 2021/22 and

Beyond,' NHS Borders is committed to implementing the Vaccination Transformation Programme and plans to commence a programme of work to identify the future model of delivery and work towards the operational delivery of the Vaccination Transformation Programme.

7.5.6. We will consider the interface with any future COVID-19 vaccination programme as part of the planning of the Vaccination Transformation Programme. However we will only plan a future COVID-19 vaccination programme when further information becomes available on the expected need for future vaccinations, which we expect to be based on antibody duration after vaccination, and / or the need to deliver any vaccinations against future variants of COVID-19.

7.5.7. Our Vaccination programme structure has been developed on a non-recurrent basis, but we will continue to evaluate this and may need to make recurrent investment in due course.

7.6. **Infection Control**

7.6.1. Infection Control Practice and Capacity

7.6.2. The ongoing need to support care home and care at home services requires ongoing infection control capability and capacity to implement further changes in national guidance, respond to clusters/outbreaks (including influenza and norovirus) and support delivery of high quality care through training and education. This requires sufficient infection control nursing capacity for site visits to care homes and community services.

7.6.3. The Community Infection Control Advice Service (CICAS), previously established by Public Health has now been transitioned to our infection control team. It continues to support community services in infection control and consideration as to how this function is continued in an enhanced Infection Prevention and Control Team (IPCT) is underway.

7.6.4. Recruitment is progressing to permanently increase the Infection Prevention and Control Nurse capacity by 2.0wte. Work will progress during 2021/22 to develop a single infection prevention and control team covering acute, community, mental health and LD as well as care homes and care at home services which would provide resilience and synergy.

7.6.5. Infection Control Nurses are specialist roles and there is a national shortage which has resulted in Boards generally having to 'grow their own' which requires significant personal investment by the post holder and financial investment by employers to attain the post graduate infection control qualification. Currently two nurses are working towards an MSc in Infection Control. These nurses will continue to be supported with this qualification during 2021/22.

7.6.6. The IPCT have developed a COVID-19 spot check tool which includes hand hygiene, cleanliness and PPE practice. Spot checks are regularly conducted in clinical areas and although unannounced, they are conducted in partnership with the nurse in charge to optimise the learning and improvement from this process.

7.7. Personal Protective Equipment (PPE) and Face Coverings

7.7.1. Members of the public are asked to wear face coverings when coming to hospital and face masks are provided for anyone who arrives without a face covering. In inpatient areas where patients cannot maintain 2 metres physical distancing, patients are supported and encouraged to wear masks when moving around the room and patients also wear masks when being moved between wards and departments.

7.7.2. PPE refresher training will continue to be available to staff during 2021/22. Monitoring staff practice on safe PPE use is included in a regular spot check tool used in clinical areas and full audit of infection control precautions.

7.7.3. NHS Borders has maintained capacity of trained face fit testers to support the move to the Alpha Solway FFP3 masks and meet ongoing face fit testing demand.

7.7.4. In areas where direct care is not being undertaken, but where physical distancing and all other controls are not possible, NHS Borders has issued guidance that face masks should be worn by all staff.

7.8. Cleaning

7.8.1. Cleaning frequency of public toilets and core areas was increased early in the pandemic and this continues. NHS Borders is routinely using cleaning combined detergent and disinfectant agents compliant with (EN13727, EN14348, EN14476, and EN14561). Current plans are that this level of cleaning will continue as we remobilise our services.

7.8.2. A check on equipment and environmental cleanliness is included in a regular spot check tool used in clinical areas and full audit of infection control precautions.

7.9. Social Distancing

7.9.1. Measures have been taken to improve social distancing for staff, patients and visitors. Outpatient activity plans include active clinical referral triage and Near Me appointments to reduce footfall in the buildings. Seating capacity in waiting areas has been reduced to ensure social distancing and social distancing signage is displayed in all buildings. At present the dining room in the BGH is only open to staff, ensuring physical distancing through the introduction of measures which include reduced number of seating and tables.

7.9.2. It is currently assumed that these measures will remain in place, at least until the end of September 2021, subject to new national guidance.

7.10. **Management of Nosocomial Infection in the Acute Hospital**

7.10.1. The acute hospital continues to have measures in place to support the management of nosocomial infection, and these will be reviewed as and when updated advice is available working closely with our Infection Prevention Control Team.

7.10.2. All staff members who work within a care environment or clinical area are advised to wear a face mask at all times enforced by our senior nursing team and this is audited by the IPCT

Team in the form of regular spot checks. Each area has a designated area that staff can access to rehydrate safely.

7.10.3. Staff members working within COVID-19 wards are provided with scrubs that are laundered onsite and also have fabric bags to transport worn uniforms home in for self laundering.

7.10.4. Some areas within the hospital have adopted an altered shift pattern to reduce the volume of staff arriving on duty and accessing changing facilities to reduce footfall. Work is currently being undertaken to provide additional staff changing facilities. Work remains ongoing to monitor the situation and assess any changes that may become necessary.

7.10.5. Within a ward environment, if clinical activity allows, multi occupancy beds are reduced from 6 to 4 beds. This supports physical distancing and reduced footfall into multi occupancy bays.

7.10.6. Patients are risk assessed following COVID-19 screening (and negative result) on clinical symptoms and presentation suspicious of COVID-19 and then either placed in cubicles or cohorted in multi occupancy bays as appropriate.

7.10.7. These measures are expected to be in place for the foreseeable future.

7.11. **Management of Nosocomial Infection in the Community Hospitals**

7.11.1. All community hospital reception areas have access to masks and hand gel for any person entering the hospitals who have not brought face coverings with them. We are currently allowing essential visiting only as per Scottish Government guidance which enables us to have more control over the traffic across our sites. Infection prevention & control audits and spot checks have continued within the inpatient units and actions resulting from these are being completed. Changes in guidance are cascaded to staff via staff share, emails, safety brief, notification boards and safety huddles.

7.11.2 We have reviewed and updated current cleaning schedules in light of guidance change. Collaborative working between the nursing and facilities staff takes place to maintain infection control standards. In one particular community hospital, as a result of an outbreak, we have worked with our estates team to move the location of the staff changing facilities. We continue to remind staff and follow processes for the movement of patients and are actively managing the movement of patients within bays.

7.11.3. Across the Primary and Community areas where staff are located and where patients access treatments, risk assessments have been completed to ensure that staff are able to socially distance themselves or aware of when they require to wear masks. Appropriate signage and access to masks is in place and donning and doffing training has been implemented and is continually updated.

7.11.4. Patients and essential visitors to the areas are screened for COVID-19 symptoms by use of a questionnaire prior to their visit.

7.11.5. Time has been built into the day to allow for breaks in PPE use and access to refreshments in available across the sites. Further consideration of staff wellbeing is being addresses with additional fluid stations across primary care locations. Charitable donations have supported other comfort measures for staff.

7.11.6. Service leads maintain close contact with the infection control team to monitor potential outbreaks of all infections, for example patients with GI symptoms would initiate closure of a bay or ward depending on severity.

7.11.7. These measures are expected to be in place for the foreseeable future.

7.12. Safe/segregated pathways - Acute Hospital

7.12.1. NHS Borders has developed pathways for the safe segregation and management of elective and non-elective patients. These include arrangements for testing all non-elective patients at the point of admission, stringent protocols for the pre-surgical assessment of elective patients including COVID-19 testing and isolation procedures which patients are required to follow prior to their scheduled admission date.

7.12.2. Capacity within outpatient departments has been restricted to ensure that required social distancing measures can be maintained at all times, to allow for enhanced cleaning of equipment and shared spaces, and to ensure that patients feel safe attending hospital appointments where this is deemed absolutely necessary.

7.12.3. As part of our initial remobilisation plans we established a separate surgical inpatient ward for the management of screened elective patients, and have ensured that segregation of elective and non elective activity is maintained through the establishment of elective only / elective first operating lists, separate arrangement for post operative recovery and care, and screening of staff working in close contact with all elective patient groups. This has included COVID-19 symptom checkpoints for staff at the start of their shifts, and the roll of out of routine lateral flow testing to all patient facing staffing groups.

7.12.4. Inevitably these changes have had a significant adverse impact on the operational efficiency of our elective and non elective processes. This is primarily a result of a loss in associated economies of scale from working within smaller segregated teams and wards, and a loss in operational flexibility across elective and non elective capacity.

7.12.5. Our current assumption is that arrangements for the safe segregation of elective activity will be required for at least the first half of 2021/22 in line with guidance issued to Boards. While every effort has been made to accommodate changes within existing resources, provision of a separate elective inpatient ward has increased our nursing requirement on a fixed terms basis, the additional cost of required staff is £250k for first 6 months of 2021/22.

7.12.6. We have also made provision for the safe segregation of elective patients requiring an enhanced level of care (HDU/ICU) post operatively through the creation of a Post Anaesthetic Care Unity (PACU). In the short term this has been achieved by utilising our theatre staff and restricting capacity for elective operating. Planning ahead we would want to make provision for reinstating elective capacity lost to PACU while this requirement

remains in place. Assuming a requirement to retain for up to 4 patients for the first 6 month of 2021/22 this is likely to cost an additional £650k.

7.12.7 No assumption is yet included for any need to extend this requirement for the remainder of 2021/22. If this is required this will need to be funded or activity levels reduced accordingly.

7.13. **Safe/segregated pathways - Primary & Community Services**

7.13.1. NHS Borders has worked to develop safe and segregated pathways for our patients, the public and our staff across our Primary and Community Services. A significant level of remedial works has been undertaken to ensure that our buildings are compliant with Health Protection Scotland COVID-19 guidance and Scottish Government/ Healthcare Improvement Scotland iHub 'Remobilising General Practice[3]' guidance.

7.13.2. A review of our Primary and Community estate has also been undertaken from a Health and Safety Perspective to ensure that there is appropriate social distancing and other measures to encourage this.

7.13.3. All patients are tested for COVID-19 prior to transfer from our Acute Hospital to Community Hospitals. Lateral Flow Testing has been implemented in line with the nationally agreed parameters for primary care and community staff and the COVID-19 vaccination programme has commenced for our patient facing Health staff and Social Care staff, which we have seen a very high uptake rate for.

7.13.4. These measures are expected to be in place for the foreseeable future.

7.14. **Safe/Segregated Pathways - Mental Health and Learning Disability Services**

7.14.1. Community services continue to adopt a Red/Amber/Green (RAG) approach to clinical and risk management of their patients.

7.14.2. At the onset of the pandemic, mental health services conducted a full risk assessment across all their clinical and office spaces relating to social distancing measures. They adjusted and implemented measures to support this in order to safeguard and protect both staff and patients, and these measures continue. This is complimented by adherence to national guidance in relation to the safe use of PPE both within the inpatient and community settings.

7.14.3. The use of Near Me continues to be the first and preferred option for initial assessment appointments and routine appointments within all our community teams. The platform has also been introduced to all inpatient wards to support minimising traffic and visitors to our inpatient facilities.

[3] COVID-19: Remobilising General Practice – Risk Management. Available from: https://ihub.scot/media/7179/covid-19_gp-resource-pack-final.pdf

7.14.4. Inpatient wards have maintained a high standard in relation to infection control guidelines. Despite this there unfortunately we experienced an outbreak at the beginning of January 2021 within one of our wards. Staff and services responded swiftly to contain the spread of COVID-19 with only a very small percentage of infection to the patient population. Standard Operating procedures remain in place to support and manage any patient suspected or indeed testing positive for COVID-19. All wards have completed a risk assessment specifically for the implementation and return of visitors to our wards and appropriate safety measures have been implemented. A further outbreak occurred recently within our support services linked with the Learning Disability Service. The Learning Disability Service provided staff and support to the service in order to support and maintain the clients within their own home setting.

7.14.5. These measures are expected to be in place for the foreseeable future.

7.14.7. The reintroduction of patient visiting within mental health wards has taken place in line with Scottish Government guidance.

7.15. **Surge Capacity - Acute Hospital**

7.15.1 As we again turn our efforts to remobilising our services it is essential that we continue to plan to respond to any further surge in suspected / positive COVID-19 patients, including ICU beds.

7.15.2. There remains the ability to create up to 20 ICU beds in response to increased COVID-19 activity and to re-purpose up to 118 non-ICU COVID-19 inpatient beds in the Borders General Hospital. Within this it should be noted that when the capacity is needed for more than 22 COVID-19 inpatients or 4 COVID-19 ICU patients it is expected that our elective profile will need to be reduced. A plan has been developed which would allow for up to 6 patients on Continuous Positive Airway Pressure (CPAP) outside ICU, in a COVID-19 Higher Observation Unit (CV HOU). This unit would be opened at the point at which capacity is required to limit ICU expansion into Theatres, as with our recent increased demand. This unit is created through the displacement of our medical Higher Observation Unit into MAU. As such, this limits front door capacity and thus our ability to deliver the Emergency Access Standard. Hence this capacity would not be activated until require to relieve pressure on ICU.

7.15.3. The ICU COVID-19 surge plan remains as per the initial COVID-19 response. With expansion into Theatres through a reduction in theatre activity we can create up to 20 ICU spaces. Following the initial wave of COVID-19 we have been able to make changes to our ICU footprint to allow up to 3 ventilated COVID-19 patients to be treated, an increase from 1 patient, before Theatres would need to be converted to ICU capacity and routine surgery stopped.

7.15.4. There would be a requirement for additional staff if surge beds opened. We now have a larger pool of staff with a greater range of skills as a direct result of the initial COVID-19 surge, and are using a range of strategies to ensure that these skills can be maintained. Nurses were redeployed to high acuity areas such as ICU and HDU during the respond phase and maintaining and updating these staffs' skills in High Dependency and Intensive care is continuing by sharing of theatre and recovery staff to these areas. To ensure

resilience and capacity within the nursing workforce we will proactively recruit to vacant posts.

7.15.5. Early in 2021/22, there will be a decision on moving the location of our first COVID-19 ward from its current home, the Margaret Kerr Unit (MKU), to a separate longer term facility. There will be revenue implications to this move this is critical to the return of palliative care services to the MKU environment.

7.16. **Surge Capacity - Community Hospitals**

7.16.1. Our community hospitals have a combined bed base of 92 across all four sites with the ability to create an additional 9 bed should COVID-19 levels significantly increase, although this is caveated based on securing the additional staffing required to open these.

7.16.2. We also have the ability to increase capacity, if required, within our Home First service. Home First capacity varies across the footprint of NHS Borders however usual caseload numbers are between 100 - 110 patients per day with the ability to increase to 110-120. This ability to flex is achieved through the relaxation of admission criteria to accept patients onto the caseload who do not have a start date for their package of care, extending the time patients remain in the service to over 6 weeks and working in partnership with care providers to share caseload.

7.17. **Surge Capacity - Mental Health Inpatient Wards**

7.17.1. During the response phase to COVID-19 our Mental Health Inpatient units considered their clinical area for infection management aligned to mental health clinical management. Each ward was able to designate part of the ward as an area to manage any potential COVID-19 positive patients.

7.17.2. There are no surge beds within Mental Health Wards; an options appraisal took place to look at the Galavale site however the environment was not safe to appropriately manage violence and aggression or infection control issues.

7.17.3. We have been experiencing a significant raised level of occupancy and acuity, and are regularly using all of our Mental Health inpatient beds. The level of occupancy and acuity is changeable on an ongoing basis. This increase is matched in our community mental health services and although data is currently limited due to small numbers and short timescales the impression is increasingly one of increased Mental Health need. To support this new referrals are triaged and the level of risk assessed to deliver an appropriate response.

7.17.4. In Mental health we review current bed states; referrals and acuity within all areas and consider capacity across the whole service and deploy staff accordingly within the service. We do this as we have no surge beds and if the demand is in the community we need to ensure this is supported to prevent admissions to the wards.

7.17.5. It is essential within mental health that we manage the capacity and demand in all areas to prevent deterioration of community patients in light of having no areas suitable for surge beds.

7.18. **Impact of Long COVID-19**

7.18.1. NHS Borders acknowledges the need to provide a range of information, signposting and clinical input for those recovering from COVID-19. We have seen a range of medical, physical and psychological symptoms reported by clinicians both in Primary and Secondary care. Relevant stakeholders have been brought together to establish current services and pathways open to these patients alongside the development of signposting and patient information which has been placed on the NHS Borders website.

7.18.2. An audit by the Occupational Therapy service has followed a cohort of patients discharged from the Borders General Hospital and Community Hospital to measure functional outcomes, fatigue levels, and mental welling impact of COVID-19. Informal feedback from GP practices across NHS Borders has identified ongoing fatigue as the most common symptom reported with several patients from each practice that would benefit from ongoing follow-up.

7.18.3. The need for a Board-wide approach to ensure appropriate equity of service has been identified and the Board has appointed a COVID-19 Clinical Lead to provide clinical and strategic direction for this work. A clinical network with a spectrum of relevant stakeholders will seek to establish clearly defined pathways and appropriate services for this patient group. The Scottish Government framework for COVID-19 Recovery and Rehabilitation alongside a growing body of evidence and national Benchmarking will help guide NHS Borders approach to delivering safe, effective, patient-centred care for those recovering from the short and long term effects of COVID-19.

7.19. **Supporting the Safe Provision of Adult Social Care**

7.19.1. The Strategic Oversight Group for Care was brought together early in the onset of the pandemic, along with an operational group to undertake, monitoring visits and support for all care homes and Care at Home providers within the Borders. Both groups have a full representation across Public Health, Nursing, Care Provision, Social Services, Social Care and also the Care Inspectorate.

7.19.2. These groups originally met every day, and now meet three times a week. Both the strategic group and the operational group have become essential components to assure that effective practices are in place across these services. The group are now very experienced in utilising data to identify issues with individual providers, and in the follow up interventions which have been necessary. These interventions have always been choreographed in conjunction with the Care Inspectorate, the District Nursing teams and the Community Care Reviewing Team of the Local Authority.

7.19.3. The oversight group initiated a weekly collective meeting with every Care Home in the Borders; this has now evolved into a joint group of Strategic Care Managers and Service Owners, chaired by the IJB Chief Officer. This group met weekly over “TEAMS” and now meets on a monthly basis. These groups are now a permanent feature within the Health and Social Care Partnership, with a growing agenda.

7.19.4. Both these groups have been and will continue to be supported through the NHS Borders Infection Control Team, the Public Health Testing Team. The Strategic Care Oversight group have commissioned, monitoring visits for infection control and for the quality of care,

aspects of this monitoring are escalated to the oversight group and appropriate action and intervention has been directed from there as required.

7.19.5. The IJB and its Strategic Partnership Group, have representation from "Carer Groups" within the Borders. Work continues through these groups and directly through Social Care to provide on-going support in households facing the constraints during "lockdown".

7.19.6. In addition the Health and Social Care Partnership introduced "locality assistance hubs", based around our five Adult Social Care Local Teams to support initially those vulnerable households and those with residents who required to be shielded. These hubs have now had further services coalesce around them, offering multi- disciplinary support to local communities.

7.19.7. Immediately prior to the pandemic and throughout its course to date, teams of Local Area Coordinators have been deployed throughout these five localities. These teams have been offering a range of services to support individuals and vulnerable groups. A further cohort of these workers, funded through the PCIP, are now supporting a new initiative called "Renew" which provides lower level, but wide spread support for residents with Mental Health Issues. These teams operate through referrals from GP practices as well as other services in each locality.

7.19.8. The ending of the UK's Transition Period with the EU, remains a concern for all services within the partnership. Both the Council and the NHS Borders have been preparing for this and workforce information has been collated and advice offered where necessary. A number of reserve teams of staff have been prepared, should they be required in areas impacted by COVID-19. This contingency will remain available.

7.19.9. New relationships have been developed, and old ones renewed, through the necessities brought about by the pandemic. The Borders has a much closer relationship with the independent sector, which is quality driven flexible and agile in its response. This has been appreciated across all partners, and will be a very sound footing for the implementation of the recommendations of the Feeley Report, particularly in terms of the co-production of new commissioning arrangements.

Public Health

8. The on-going response to COVID-19 has seen unprecedented changes in the level and type of public health challenges. There is therefore the need to review and strengthen the capacity of the Public Health team. To that end pre-COVID-19 work streams are being re-established to support national public health outcomes as outlined in our Director of Public Health report (http://www.nhsborders.scot.nhs.uk/staying-healthy/public-health-information/borders-reports-and-data/). In addition several services have been further developed to meet the challenge presented by COVID-19, these include:

- Testing – to ensure the safe delivery of testing to groups such as staff, care home residents etc. and in the investigation of cases of COVID-19. As well as being a key component of offering Polymerase Chain Reaction (PCR) tests to symptomatic key staff (or their household members) this service has also been instrumental in the roll out of

Lateral Flow Device (LFD) asymptomatic testing as well as expanding the community testing offer.

- Health Protection – to support response to outbreaks and the development and delivery of vaccination programmes e.g. previous 'flu campaign and COVID-19 programme whilst also carrying out normal health protection duties responding to notifiable diseases, environmental and other risks. This has seen additional staff brought into the team either through appointment or short term secondment (to respond to increased need for capacity due to COVID-19 cases).

- Tracing – NHS Borders has established a now experienced tracing service to meet the specifications of the national tracing programme with the skills and ability to respond to cases within complex settings.

8.1. The needs of these services continue to be considered alongside other such cases and requests for additional resources in order to remobilise services across our health service. These enhanced services bring challenges in terms of need for resources. This is not only limited to financial resource but also includes need for space, equipment to work from home and the availability of people with the appropriate skill mix. Prioritisation decisions therefore continue to be taken to allow completion of "must do" tasks.

8.1. **Test & Protect**

8.1.1. NHS Borders has a well-established Contract Tracing Team in place from 8am to 8pm, 7 days a week. This service is staffed both by existing staff redeployed from other services (adding pressure to our wider service). However we have recently progressed further recruitment to put this team on a longer term footing and release seconded staff back to their core service as well as ensuring the staffing for Test & Protect is more sustainable over the coming months.

8.1.2. It is assumed that we will require a Test & protect service throughout 2021/22.

8.2. **COVID-19 Screening and Testing Policies**

8.2.1 NHS Borders is committed to following national guidance in the development and implementation of testing policies. NHS Borders Testing Policy group provides multi-stakeholder advice on the implementation of the local implementation of guidance and policy.

8.2.2. Pathways for testing groups identified in guidance have been developed through multidisciplinary groups and are overseen by a weekly meeting of our local COVID-19 Testing Policy Group including public health, testing team, laboratory, infection control and clinical representatives.

8.2.3. We are looking at all the local and national testing arrangements that are available to people in the Borders to ensure that we have a joined-up and effective approach to both the access to carrying out testing facilities and the laboratory testing arrangements.

8.2.4. There is a limited capacity for local same day laboratory testing and we need to ensure we use this for the most critical areas and use national testing facilities, such as Lighthouse and the Regional NHS Laboratory, for testing where time is less critical (e.g. for routine testing).

8.3. Community COVID-19 Testing

8.3.1. NHS Borders is leading a Borders partnership of public health, health improvement, military, fire and rescue service and local authority to implement community COVID-19 testing, including asymptomatic testing. Scottish Government has agreed funding for the Borders proposal to 30 September 2021. The project centres on:

- Community asymptomatic lateral flow device testing (LFT)
- Subsequent PCR testing of positive LFTs
- Liaison with SEPA on waste water sampling to target community testing
- Wraparound public health measures to support positive cases to isolate
- A detailed communications plan

8.3.2. The project is being implemented in two phases. Phase 1 commenced on 25 January 2021 with the establishment of a Mobile Testing Unit (MTU) in Hawick on 7 days per week for both PCR symptomatic and asymptomatic testing. Phase 2 will be an agile testing facility in partnership with Scottish Fire and Rescue colleagues using fire stations or adjacent premises in Borders locations in a small and gradual way with flexibility to scale according to virus levels. The military will operate the community testing services for 6-8 weeks, following which NHS Borders will assume operational control. Phase 2 is expected to commence in March (date to be confirmed) with initial funding to 30 September 2021.

8.4. Wider Public Health Activities

8.4.1. We will be responding to the wider health agenda through public health analysis of the negative impact of COVID-19 as outlined in the recent Chief Executives letter, "How the health of Scotland has been Indirectly Impacted by COVID-19"[4]. The public health team as a whole, including our health improvement team are considering the recommendations in that paper as set out below:

- Implement remobilisation and renewal, with a focus on prevention and improving health
- Renewal and the health and social care sector contribution to economic and community wealth building
- Renewal to long term sustainability
- System support for Staff Health and Wellbeing

8.4.2. Health improvement/reducing health inequalities – Public Health are contributing to the work currently underway to develop an enhanced strategic approach to the Board's role in health inequalities. This builds on the analysis undertaken in response to the Chief Executives letter, "How the health of Scotland has been Indirectly Impacted by COVID-

[4] Public Health Scotland, How has the health of Scotland been indirectly impacted by COVID-19 and how can NHS Boards mitigate for this impact? Working paper for NHS Chief Executives Renewal Meetings Version: 16/07/2020

19"[1]. All health improvement staff currently deployed to the COVID-19 response will return to their substantive roles from 1 April 2021. Planning is underway to reshape work and capacity to address public mental health concerns in particular relating to children and older adults and anti-poverty.

8.4.3. Alcohol and drugs – increased (virtual) opportunities for recovery activities increased during COVID-19 and services were maintained. Re-introduction of drop-in clinics will commence as soon as it is COVID-19 safe to reduce barriers to access and increase availability of same day prescribing and harm reduction advice

8.4.4. Risk and Resilience functions have continued throughout COVID-19; however a number of actions have necessarily been reprioritised. It is likely that additional capacity will be required to support these functions.

8.4.5. As part of the COVID-19 work Public Health colleagues continue to support assurance process of Borders care homes in line with Scottish Government guidance e.g. through Care home oversight group and directly.

8.5. **Screening Programmes**

8.5.1. Scottish Government identified all national screening programmes as a priority and has asked Health Boards to make arrangements to guarantee the maintenance of all screening programmes throughout this lockdown. NHS Borders recognises that COVID-19 and its transmission prevention measures pose challenges to the ongoing maintenance of the screening programmes and local remobilisation plans.

8.5.2. During the first Lockdown in March 2020, a national decision was made to pause the national screening programmes, with the exception of the Pregnancy and Newborn programmes. There was a phased approach to screening programme resumption. Programmes that deliver part of their remit in community based locations have faced issues with accommodation and waiting room access, as some sites remained closed or had been repurposed for COVID-19 related activities. As a result, the AAA & DES programmes focused on providing a central service at the BGH. This significantly reduced the overall screening capacity that could be delivered. Although access to these locations has now resumed, screening capacity remains reduced on account of PPE, waiting room restrictions and clinic room access, as these areas are shared with other services.

8.5.3. NHS Borders is committed to:

- Prioritise the maintenance of screening programmes during this lockdown and take assurance that all national screening programmes are currently being maintained.

- Ongoing maintenance of the screening programmes and consideration of accommodation/venue requirement and associated resource requirements within local service delivery remobilisation plans.

[1] Public Health Scotland, How has the health of Scotland been indirectly impacted by COVID-19 and how can NHS Boards mitigate for this impact? Working paper for NHS Chief Executives Renewal Meetings Version: 16/07/2020

- Consider the potential impacts and unintended consequences (potential increase in inequalities) on delivery of the national screening programmes as a result of operational decisions or initiatives implemented in order to manage the COVID-19 pandemic.

- Note the challenges and impacts of maintaining the screening programmes during the COVID-19 pandemic, especially the likelihood of not meeting the national screening programme KPIs.

- Note the limited scope of implementing mitigating actions to reduce the impacts on screening programmes and outcomes during this time, as a result of the pressures on delivering national screening programmers through associated delivery services during the COVID-19 lockdown.

Delivery of Essential Services

9. **Impact of Winter and Pandemic Surge on Acute Hospital**

9.1. The 2020/21 Winter Plan created increased capacity to the Acute hospital through additional medical beds, increased intermediate care capacity in the community and targeted support for services critical in the delivery of reduced length of stay. Due to the requirement to create COVID-19 inpatient capacity in response to pandemic activity beyond the first COVID-19 wave, and in line with the 2020/21 Acute Services COVID-19 Winter Plan, winter medical ward capacity was repurposed to COVID-19 capacity.

9.2.1 Assuming a similar level of Scottish Government funding and Health Board funding as 2020/21, the 2021/22 Winter Plan will build on the previous year's plan and repeat successful investments from previous years; strengthening weekend medical cover, increasing workforce levels in the out of hours period in the Emergency Department (ED), increasing AHP capacity and robust operational processes to manage safe flow.

9.3. In 2021/22, work will continue to keep delayed discharge numbers low building on the joint working that has delivered reductions in Acute Services delayed discharges over the previous 12 months. The Borders Urgent Care Centre (BUCC) will be extended to deliver more urgent care pathways out with the Emergency Department (ED). Work to develop a frailty model, paused in response to the pandemic, will be restarted should COVID-19 activity allow. Finally, and again if COVID-19 activity allows, GP assessment services, Gynae Surgery Assessment Unit (GSAU) and Acute Assessment Unit (AAU) will be removed from the ED footprint.

9.4. COVID-19 surge meant our ability to continue to deliver routine elective surgery and routine outpatient appointments was reduced significantly during the second wave. Whilst a robust seven-stage COVID-19 surge plan will continue to be in place that can create up to 118 non-ICU COVID-19 beds through the hospital, invoking this would again have the same impact on non COVID-19 and our routine elective programme.

9.1. **Impact of Winter and Pandemic Surge Primary & Community Services**

9.1.1 Primary & Community Services are heavily involved in the organisation's planning and response to winter pressures. This winter the following plans were prioritised:

- Enhanced reablement in acute and community settings
- Near Patient Testing in GP practices to reduce hospital attendances
- Development of Discharge to Assess pathway through the Hospital to Home (Home First) service

9.1.2. The Primary and Community Services team work closely with Social Care to effectively manage and reduce delayed discharges on an individual patient basis. In addition, the Primary and Community services team work closely with colleagues in acute services to support acute pressures, providing a tailored response based upon the need and the ability of primary and community services to provide this support (e.g. in-reaching of the Home First hospital to home service).

9.1.3. The 2020/21 Winter Plan created increased capacity to the Acute hospital through additional medical beds, increased intermediate care capacity in the community and targeted support for services critical in the delivery of reduced length of stay. Due to the requirement to create COVID-19 inpatient capacity in response to pandemic activity beyond the first COVID-19 wave, and in line with the 2020/21 Acute Services COVID-19 Winter Plan, winter medical ward capacity was repurposed to COVID-19 capacity.

- Re-ablement is embedded throughout our pathways
- Independence is promoted,
- Assessment for long term care does not happen until the patient has had a chance to recover from their acute episode, and does not occur in an acute hospital environment
- People are transferred to as homely a setting as possible
- That we develop our stepped care approach to enhance the step-up of patients from community and prevent acute hospital admissions
- We work with the voluntary and third sector to develop appropriate pathway 0 services across our localities

9.1.4. Further development of interfaces with Scottish Ambulance Service (SAS), GPs, Pharmacy, Dental and Optometry will be pursued under the Reshaping Urgent Care agenda to improve the experience and outcomes for patients and staff.

9.1.5. Each service has created individual staffing and service escalation plans as part of COVID-19 resurgence under the direction and guidance of COVID-19 Silver Command's to form an Escalation Framework and Tactical Resilience Plan. Each plan is RAG rated based on a range of indicators including staff absence levels, physical capacity, increased demand, internal incidents, and policy drivers. These escalation plans and triggers have been enacted since mid-November 2020 with various staff absence and activity triggers reached by this point to support community clusters/pressures (e.g. residential care outbreaks/ affected primary and community services), and acute hospital pressures.

9.1.6. In addition, each service has been clinically prioritised to support decision making around service prioritisation when another primary & community service or wider system service is under pressure. This process has assisted in the communication with services and the approach to the deployment of staff to support organisational pressures.

9.1.7. As at time of submission, the following services have already been stood down or reduced with staff redeployed to support other services in the COVID-19 response:

- Hydrotherapy
- Cardiac Rehab
- Oral Health
- Routine MSK Physiotherapy
- All routine outpatients
- Public Dental Service significantly reduced staffing
- Day Hospital
- Falls Prevention
- Long term conditions Rehabilitation
- All routine Community Dietetics and Speech and Language Therapy Routine Podiatry and Audiology
- Routine Paediatrics
- School Immunisation Team

9.1.8. 15 Allied Health Professionals (AHP) have already been employed/ redeployed from step-down services to support AHP input to the acute hospital including increased 7 day ICU input, cover in COVID-19 wards, and across all ward areas to support patient flow.

9.1.9. We look forward to resuming our normal service as de-escalation of COVID-19 activity and impact occurs across the system.

9.2. **Impact of Pandemic Surge Mental Health & Learning Disability Services**

9.2.1. Mental health services have seen an increase in activity since the beginning of the pandemic in 2020. In March 2020 it was predicted nationally that mental health services would see an increase in demand by:

- An 8% current worsening of the incidence of mental health disorders. This is particularly for anxiety and mood disorders and particularly in young people and females.
- 10% increase in psychosis presentations.

9.2.2. Since March 2020, NHS Borders Mental Health services has seen an increase in demand, occupancy of inpatient wards and acuity in our acute admissions unit.

9.2.3. There has been an increase in occupancy in Huntlyburn Ward and there is a need to address the periodic shortfalls in capacity. There are no surge beds within mental health therefore it is essential that we are able to ensure adequate staffing in all areas of the service to prevent admissions to hospital, provide support in the community to reduce waiting lists and provide timely discharges.

9.2.4. Bank usage and extra hours and overtime has increased within the mental health wards and the main reason for this has been high acuity and sickness.

9.2.5. There has been an increase of the number of episodes for applied continuous observations and an increase in trend of incidents relating to self harm within the Huntlyburn ward which demonstrates the level of acuity in admissions.

9.2.6. There are also increasing waiting lists to the Adult Community Mental Health Teams (CMHTs) which is delaying people's access to services in both CMHTS and Mental Health Older Adult Services.

9.2.7. During the pandemic there has been, and continues to be, less treatment and more stabilisation of peoples mental health due to the impact on staffing levels and the ability to a deliver suitable treatments.

9.2.8. The requirement of increased working from home has impacted on staff in terms of their wellbeing due to lone working, along with having to deal with the COVID-19 pandemic. Risk assessments have been carried out as required and staff are shielding which is all a direct impact of the pandemic surge. Through the local risk assessments there has been a decrease in the range of work some staff are able to undertake.

9.2.9. Before the pandemic, people were already facing considerable health inequalities. The impact of the pandemic has increased peoples isolation and potentially health and social care inequalities as a result. We wait to see the long term impact on the population.

Remobilisation of Primary, Community & Social Care Services

10. **Introduction**

10.1 NHS Borders fully recognises the central importance of primary care services, and our Health Board Primary Care staff and primary care independent contractor colleagues have been central to our local remobilisation planning process. Our Primary and Community Services (P&Cs) clinical board has established a number of recovery workstreams led by primary care staff, which feed into the NHS Borders Recovery Plan Group.

10.2. A focus has been put into remobilising services safely whilst ensuring ongoing sustainability in primary care during what is a challenging period with ongoing prevalence of COVID-19. Dental Services and Community Optometrists are following the Scottish Government's steer from the Chief Dental Officer and Optometry Deputy Director. All GP practices in NHS Borders remain at Level 1, and work is ongoing to restart Cervical Screening non-routine recalls in line with the guidance from NSS, the management of chronic conditions, and undertake flu planning.

10.3. Our Clinical Interface Group has focused on COVID-19 recovery across all three clinical boards in the organisation, along with involvement from our General Practitioner colleagues, and continues to have a busy and productive agenda. We are about to commence a pilot of the Community Treatment and Care service phlebotomy service in our

West Cluster (Tweeddale), and plan for this service to expand to cover both PCIP and further secondary care support.

10.4. In terms of vulnerable groups, we have worked to continue all primary care and community services that support vulnerable groups for as long as possible, however in December we had to risk assess the situation and reduce some of these services as described above in page 26-27 to support the COVID-19 pandemic response associated to increased COVID-19 hospital occupancy. Once the situation within NHS Borders de-escalates, we will reprioritise these services.

10.1 **Rehabilitation services**

10.1.1 The impact of the COVID-19 pandemic has had far reaching affects into many parts of the Scottish Borders population and has impacted many different clinical specialties. One of the clearly identifiable outcomes of national and local 'lockdowns' has been the increase in frailty across our population. This is influenced by acute and long term conditions, malnutrition, reduced physical activity, social isolation, reduced functional capacity, and deterioration in mental wellbeing. The combination of the above has resulted in an increase in medically complex and frail patients entering our Health and Social Care Services. These patients are requiring input from a wide range of medical specialities and are requiring longer to recovery and requiring significantly more rehabilitation in order to return to independence in the community. Patients who are unable to return to a level of function independence will require significant long term social care support.

10.1.2. Whilst rehabilitation services within the acute and community hospitals have remained ongoing throughout the pandemic, some community rehabilitation services have been stepped down in line with service escalation plans. The need to remobilise rehabilitation services is a significant priority to address this ongoing need and to prevent needless hospital admissions. Services such pulmonary rehabilitation, cardiac rehabilitation, long term condition rehabilitation services, day hospitals, falls prevention services are all essential to maintain the health of the population. The 'Older People's Pathway' work referred to earlier provides a structure to ensure that appropriate services are in place across NHS Borders and to ensure smooth transitions across the Health and Social Care Partnership.

10.1.3. The Falls Prevention Strategic group is reviewing our community falls prevention and patient pathways to ensure this patient group receives the rehabilitation required, and a 'Discharge to Assess' and reablement intermediate care service allows AHP Therapists to lead on rehabilitation in people's homes. The Scottish Government framework for COVID-19 Recovery and Rehabilitation provides not only guidance on services and pathways for patients recovering from COVID-19, but also principles for wider rehabilitation services across NHS Borders.

10.2. **Management of Delayed Discharges**

10.2.1. The Scottish Borders Health and Social Care Partnership has prioritised the Older People's Pathways as one of its strategic priority areas, and work is ongoing to develop these pathways in the Borders. At the beginning of December we enhanced our 'Home First domiciliary reablement service' with discharge to assess and trusted assessment. This

ensures that more people have the opportunity to recover in their home environments, receive reablement and have a better outcome, as well as reducing the requirement for long term care.

10.2.2. Supporting patients to leave hospital after the acute treatment phase is done as business as usual on a daily basis within NHS Borders. The daily Integrated Huddle at the Borders General Hospital (BGH) plans complex discharges across the hospital ensuring smooth transition to community capacity.

10.2.3. Delays are reviewed by all Business Units as a matter of routine and escalated as appropriate. There is a weekly community hospital review of patients who are delayed for discharge. This winter we have developed an integrated health and social care whole system weekly meeting to managed delayed discharges and have been successful in managing to reduce the number of delayed discharges and associated occupied bed days over the past 2 months.

10.2.4. Morning and afternoon Multi Disciplinary Team meetings occur on each ward within the acute hospital with representation from a broad range of professions, to manage discharge at the ward level. In high-discharge areas, like the Medical Admissions Unit, this includes Social Care and third sector representations such as an in-reach team from The Red Cross. To ensure a whole-system overview of complex discharges, a daily Integrated Huddle was developed during the first COVID-19 wave with representation from wards.

10.2.5. When discharging patients to care homes NHS Borders ensures compliance with relevant Health Protection Scotland Guidance.

10.2.6. NHS Borders proactively review discharges by measuring the numbers of people discharged from hospital over the age of 65 to see how many have gone home with minimal support, home with reablement support, to a bed based facility, or straight to long-term care, in line with the Institute of Public Care framework5. These outcomes are considered by the management teams on a weekly basis in our joint NHS Borders/Scottish Borders Council Winter Operations Group, to ensure that we can implement local actions to get more people home.

10.3 **Home First**

10.3.1. The Home First Service has continued to be a vital service maintaining patient flow throughout the pandemic period. The service has developed into a 'discharge to assess' incorporating social work Trusted Assessment, and piloting an integrated reablement service with SBCares to deliver additional services such as evening visits and medicine administration. Working closely with Multi-Disciplinary Teams within the Acute Hospital we further developed our practices to support a timely discharge from hospital and then an assessment of needs; these are now completed in the patients' home, not hospital. An IJB commissioned service evaluation has highlighted areas for development to ensure high quality patient centred care.

[5] Institute for Public Care. Commissioning out of hospital care services to reduce delays. Available from: https://ipc.brookes.ac.uk/publications/Out_of_hospital_care_to_reduce_delays.html

10.3.2. Being a pivotal team supporting Older People within the Intermediate Care Pathway, we recognise the increased frailty within this group of the population. Our remobilisation will focus on balancing the caseload of this service so that we can respond promptly to prevention of an admission to hospital and keeping people at home at the same time as maintaining a robust Discharge to Assess Model.

10.4 **Pharmacy**

10.4.1. The pharmacotherapy team working in GP practices are taking forward serial prescriptions with practices, supported by Community Pharmacy Borders and NHS Borders Primary Care Pharmacy Teams. All 23 GP practices are issuing serial prescriptions; this is viewed as mitigation to the high levels of prescription ordering shortly after the first coronavirus lockdown.

10.4.2. All Community pharmacies are operating fully with the exception of face to face consultations in consultation rooms. The use of remote consultations using telephone has been adopted and Near Me is continuing to be promoted to all pharmacies.

10.4.2. Remote access to practices allowing Pharmacists and Technicians to work off-site is being used in a number of practices. Remote access helps GP practices struggling to comply with social distancing guidance and reduces footfall and therefore the potential spread of infection.

10.5. **School Nursing and Health Visitors**

10.5.1. Our School Nursing and Health Visiting service remobilisation plans include delivering Scottish Government guidance on universal services with a particular focus on supporting and protecting vulnerable, at-risk and looked-after children and young people within the context of increasing adversity and reduced visibility due to COVID-19 lockdown.

10.5.2. The School Nursing team work closely with schools and the wider Child Health Workforce to reduce inequalities and reduce the impact of adverse childhood experiences for our children and young people. The largest proportion of the workload is with the most vulnerable groups; Child Protection work, Looked After Children's health needs and those with a higher level of emotional challenges, often deflecting inappropriate referrals from CAMHS and working with challenging and hard to reach families to improve outcomes from children. There is recognition of the role to achieve the principles of Getting It Right For Every Child (GIRFEC).

10.5.3. Health Visitors are continuing to deliver a modified service providing support and advice to families as required. Much of this is happening via telephone or Near Me video consultations but where clinically indicated and individually risk-assessment, Health Visitors are still providing face-to-face care and support as required with child protection work and supporting vulnerable and at-risk children and families an absolute priority. There are however a number of staff who are shielding and therefore only able to provide remote consultations, but in these situations contingency arrangements are in place to ensure other Health Visitors provide the home visiting element as indicated.

10.6. **Allied Health Professionals (AHP)**

10.6.1. Allied Health Professionals have been central to NHS Borders response to COVID-19 and will be crucial in the remobilisation of services and as we seek to deliver safe, effective, patient-centred services. AHP services remain essential to the 3 strategic aims of the IJB: improving the health of the Scottish Borders population through health improvement and prevention of admission, improving flow through our hospital and community pathways, and to improve the community capacity by facilitating self-management. Alongside refreshed remobilisation plans, in 2021 all AHP services will be developing Service Specifications to clearly articulate the services provided, the models and pathways used, and the governance and outcomes provided. This will ensure NHS Borders AHP services continue to provide high quality and efficient services with appropriate governance and outcomes in place.

10.7 Occupational Therapy

10.7.1. Occupational Therapy services have played a vital role within inpatient and community settings to facilitate flow through our hospital system during the COVID-19 pandemic. An increased resource within the acute setting during the initial response phase demonstrated a significant impact on patient flow, rehabilitation and reducing delays. Occupational Therapists have been key figures in NHS Borders 'Home First' service facilitating a Discharge to Assess model and Trusted Assessment in order to reduce delays and inefficiencies while working in an integrated approach with Scottish Borders Council.

10.7.2. The remobilisation of Occupational Therapy Services provides challenges due to the small staffing resource available. Ongoing pressures within inpatient settings present challenges in moving resource into a community and prevention of admission setting. It is vital for the long term health of the population and the long term sustainability and resilience of services that professions such as Occupational Therapy are based in community and primary care settings delivering services such as long term condition management, falls prevention, community reablement and rehabilitation. The increased frailty of the local population suggests that remobilisation of these services remains a significant priority in order to prevent admission/ referral to other services. Opportunities for First Contact Practitioner posts within primary care provide further opportunities to shift the balance of care.

10.8. Dietetics

10.8.1. Dietetic services have adapted significantly over the pandemic period moving a large proportion of work to virtual 'Near me' consultations. Telephone consultations have also replaced some Community clinic appointments, due to IT access and skills within their client group or client preference.

10.8.2. Ongoing critical service provision within the Acute and Community hospital setting has continued along with input into mental health and paediatric services. Domiciliary visits have been maintained for the most at risk patients residing in their own homes. Services to patients receiving home enteral nutritional support continue with more frequent dietetic review and feeding regimen amendments being required as disease progresses.

10.8.3. The impact of frailty and malnutrition has become increasingly evident throughout the lockdown period. Previously limited or redeployed dietetic input has led to an increased urgency and complexity of referrals resulting in more substantial and varied types of nutritional support being required. The numbers of referrals within this client group has significantly increased since June 2020.

10.8.4. In order to maintain the health of the population within the Scottish Borders, addressing nutritional needs and malnutrition are essential to the remobilisation of wider rehabilitation and medical services. Remobilisation opportunities exist to develop closer locality working and an MDT approach within Home First should include nutritional screening (MUST) to identify high risk patients with Dietetic resource included to ensure that they are treated in a timely manner. Dietetic services will remobilise balancing the need of inpatient services with the increasing outpatient demand. Services will remain flexible in order to meet service needs and the dietetic workforce is being developed in order to deliver sustainable services in a resilient way. Regional funding has created the opportunity for several new posts targeting Child Healthy Weight initiative and cancer services respectively providing the opportunity to demonstrate the impact of dietetic services in a wider range of specialties.

10.9. Podiatry Services

10.9.1. Podiatry services have worked collegiately throughout the pandemic supporting district nursing workforce by providing support to high risk wound care. Many podiatry services have moved to 'Near me' or telephone consultations, and the changes to service delivery have provided an opportunity to review practices and to make appropriate changes. A telephone triage service in conjunction with an 'opt in' approach to routine appointments has encouraged a self-management approach whilst releasing resource for an ever increasing urgent wound care caseload. Diabetic foot care has been noted as a significant issue in Scottish Government communication and these services have been prioritised throughout.

10.9.2. The remobilisation of services in 2021 will again provide an opportunity to review service models and modes of service delivery to ensure that podiatry is continuing to provide safe, effective, patient centred care in the most efficient way possible. Close working relationships with colleagues in Primary care will ensure that resources, space and equipment are used appropriately, and that patients have access to services in their localities. Remobilisation provides opportunities to develop further close working with pressure area and wound care services to improve efficiencies and patient services across the system. There will a continued move toward sustainable services providing timely assessment and treatment and encouraging health promotion, prevention and self management in the community.

10.10. Speech and Language Therapy Services (SLT)

10.10.1. Speech and language Therapy Services have provided ongoing input to Inpatient and community settings throughout the pandemic period. As with other services, 'Near me' and telephone consultations have been the primary method of consultation and have been extremely effective in delivering safe and effective care during the pandemic. SLT services have continued to provide Augmentative and Alternative Communication equipment as

per legislation and have continued to provide services to vulnerable patient groups such as Learning Disability services.

10.10.2. Remobilisation of Speech & Language Therapy (SLT) services will be a phased approach as inpatient demand reduces and as outpatient activities increased. SLT services play a vital role in addressing health inequalities and this will remain a significant focus as plans are made for the remobilisation of services.

10.11. Physiotherapy

10.11.1. Physiotherapy has played a vital role in supporting patient pathways across both primary and secondary care throughout the pandemic period. They have provided increased input to inpatient settings to facilitate early rehabilitation within critical care, COVID-19 and non COVID-19 wards to enable timely discharge. Physiotherapy input has also been vital in community service such as Home First and at front door of Borders General Hospital by supporting discharge to assess focus and preventing unnecessary admission. Unlike in first wave essential outpatient activity has continued across all speciality services. First Contact Practitioners playing an important role in Primary Care by preventing unnecessary GP activity and ensuring that 75% of patients are discharge to self-manage without requiring onward referral to other pressurised services.

10.11.2. As with other AHP services, physiotherapy plays a vital role in maintaining the health of the population and in preventing unnecessary hospital admission or accessing other health services prematurely. The remobilisation of services will provide significant challenges due to the increased need for physiotherapy services in the community across musculoskeletal services, long term condition management in both adults and children, and community rehabilitation services. Managing waiting lists and patient expectations whilst maintaining the flexibility to support inpatient services as required will be necessary over the coming months. Physiotherapy services will be remobilised in a phased approach in conjunction with relevant clinical specialties and services.

10.12. AHP Children and Young People's (CYP) services

10.12.1. The redeployment approach of the CYP staff during the initial phase of the pandemic has highlighted the clinical priority of these essential services. The adverse consequences of lockdown, school closures and reduced services has seen an increase in child protection numbers and has highlighted the clinical impact of reduced services, at times with lifelong impacts. During the COVID-19 resurgence of winter 2020 we have sought to protect and maintain CYP AHP services across NHS Borders in line with Scottish Government guidance. The impact of health inequalities evident in CYP AHP services has also highlighted the need to maintain local, accessible services for these children, young people and their families or carers.

10.12.2. Remobilisation of CYP AHP services will continue to clinically prioritise caseloads in conjunction with universal access to services. Working with partners within Scottish Borders Council will continue to be key and AHP services are actively involved in SBC Education projects around estate and facilities moving forward to ensure a collaborative approach across the Partnership. CYP AHP services are critical to the long term health of

the population of the Scottish Borders and services will be remobilised to provide safe, effect patient-centred care to this vulnerable patient group.

10.13. **Community Dentistry**

10.13.1. Remobilisation of NHS General Dental Services (GDS) dental practices continues to follow national guidance from Scottish Government and the Chief Dental Officer. Practices will continue to be provided with support from NHS Borders throughout remobilisation in keeping with all local and national guidance documents throughout 2021-22.

10.13.2. Regular communication from the Director for Dentistry and the Dental Practice Advisor is circulated to individual practitioners and practices to support remobilisation and mitigation processes in relation to COVID-19 staff and patient safety.

10.13.3. Support to provide COVID-19 risk assessments and standing operating procedures includes offers of pastoral supporting visits by the Health Boards Dental Practice Advisor. This has enabled practices to remobilise safely and effectively. As practices further remobilise and increase activity this support will continue.

10.13.4. NHSB will continue to work in partnership with NSS to provide practices with PPE and proved an on-going programme of face fitting for FFP3 masks to all practices and their clinical staff. Health Protection, CDPH support, community infection control advice will continue to be available at a local level to all practices.

10.13.5. Dental practice staff members have been offered COVID-19 vaccinations according to JCVI priorities.

10.13.6. Practices are signposted to NHSB Occupational Health Services and these services are available to all practice staff members providing support in relation to health and wellbeing.

10.13.7. Prioritisation of patient care in dealing with the 'backlog' of missed appointments for routine care within NHS GDS practice continues to be guided by the NHS Scotland document 'Moving Towards a Return to Routine Dental Care'. While NHS GDS dental services can provide a full range of dental care it is not business as usual. NHS GDS dental practitioners, while working at a restricted capacity have been crucial to the success of the vaccination programmes and we anticipate they will continue to support and lead within the COVID-19 vaccination programme though 2021-22.

10.13.8. Routine Combined Practice Inspections (CPI) have been suspended as agreed nationally however preparation for a resumption has commenced to provide early support and engagement with practices. To support new practices and the sale of practices, NHS Borders continues to inspect practice premises thus improving dental access and ensuring registered patients continue to receive their dental care safely.

10.13.9. The Public Dental Service (PDS) while continuing to remobilise in the face of a deployed workforce will continue to accept referrals from practices and support patients that are unable to have treatment provided in a GDS setting. Urgent dental care for patients not

registered with an NHS GDS practice is managed by the PDS emergency dental service and care continues to be provided in partnership with NHS GDS practices.

10.13.10. NHS Borders has a robust system in place to identify early deregistration of NHS GDS patients and contingency plans are in place.

10.14. **Oral Health**

10.14.1. National oral health preventative programmes including Childsmile, Caring for Smile Open Wide combine targeted and universal approaches to tackling inequalities in oral health improvement across Scottish Borders, due to pandemic adaptations are being put into place to support groups using online communication and training methods.

10.14.2. Within NHS Borders every family continues to have access to Childsmile home support, nursery/school, community interventions and an enhanced programme of care across all dental services. As part of the COVID-19 re-mobilisation plan, support is in place from education, social care, Childsmile executive and local teams to ensure the safe and timely re-establishment of daily supervised toothbrushing, access to oral health resources for use at home and near me clinics for parents, families and carers to receive 1-1 OH advice.

10.14.3. An oral health advice line has been set up to offer general oral health support, and facilitate appropriate access to dental services for parents, carers and all partner agencies involved in the aim of reducing inequalities in oral health.

10.15. **Community Optometry**

10.15.1. In keeping with the Scottish Government's Remobilisation of Primary Care, Community Optometrists are following national guidance, PCA(O)2021(1), where a practitioner determines that it is clinically appropriate and necessary for a patient to be seen face-to-face. Emergency and essential care continues to be prioritised over more routine services with patients who are at greatest risk of detriment to sight or wellbeing are prioritised first.

10.15.2. Community Optometry in the Borders acts as a 'first port of call' for patients contacting their GP surgeries for eye related complaints. GP receptionists have been instructed to advise patient callers to contact their local optometry practice for eye related complaints when filtering requests. In turn, local optometry practices will also carry out remote triage to identify if a solution could be obtained from local pharmacies first to ensure effective use of eye examination consultation appointments.

10.15.3. Although eye examinations have remained a priority service since May 2020 and has generally been working well in the Borders, it should be noted that local capacity to meet demand has been stretched.

10.15.4. Regular briefings from NHS Borders and the Area Optical Committee Chair have improved with communications cascaded to Community Practices. Matters relating to staff and patient safety (e.g. Lateral flow Testing and PPE sourcing) are high on the agenda and will be key in executing remobilisation plans.

10.15.5. Each practice has completed their respective COVID-19 risk assessment. Physical distancing, numbers of patients seen per a day and additional cleaning measures have been considered in order to be compliant with Optometry Scotland Guidelines. Local adaptations have been made to allow for the use of PPE and additional cleaning requirements. Local practices are working with a locked door/ appointment only policy to control patient numbers in practice and aid with social distancing. NHS Borders' partnership with NSS has facilitated the provision PPE to the practices. Optometry practice staff members have been offered COVID-19 vaccinations according to JCVI priorities.

10.15.6. Looking ahead, Optometry Scotland has released the latest guidance (18 February 2021) on twice weekly Lateral Flow Device testing for patient-facing workers. Whist the scheme is voluntary for individuals; Optometry Scotland encourages practices to fully support the extension of the testing programme. Local practices are currently reviewing the scheme and will be coordinating rollout with NHS Borders.

10.15.7. While community optometry services can provide a full range of eye care, it is not business as usual. Emergency appointments are given priority and measures are in place to ensure that patients are seen in a timely manner. As highlighted earlier, reduced capacity due to daily patient number restrictions and additional cleaning measures will significantly impact recovery to pre-COVID-19 patient volumes. Patient and staff safety remains paramount for practitioners; as such remobilisation plans will largely be directed by Optometry Scotland's guidelines and local lockdown easing restrictions.

10.15.8. Activity within mobile practices has increased since the resumption of routine eye care within day centres and residential centres on 7 September 2020. However, it is noted that the provision of routine eye care to patients within care homes is particularly challenging at present, and it is likely to be some time before overall activity recovers to pre-COVID-19 levels.

10.16. **COVID-19 Hub and Assessment Centre**

10.16.1. The COVID-19 Hub and Assessment Centre (CHAC) was established in March 2020 to assess patients (confirmed or symptomatic) from Scottish Borders community who have been triaged by NHS 24 as requiring local hub assessment at any point in the 24 hour period, 7 days per week. Since then the CHAC has been involved in supporting national *Community Covid Surveillance* – this is a programme to help inform scientific modelling, political decision making around social interventions and will help to maintain a functioning NHS. This service was delivered as an extension of the Borders Emergency Care Service (BECS) Out of Hours Service.

10.16.2 During the course of 2020, a Scottish Government review of changes made in the delivery of Urgent Care in response to the 1st wave of COVID- 19 concluded that efforts should be made not to return to old ways of working and Boards were directed to implement in time for winter:

- Access to urgent care for the cohort of self-presenters to ED through a national Single Point of Access though NHS24/111 (available 24/7 for urgent care)

- A Flow Navigation Centre (Hub) that would directly receive clinical referrals from NHS24 and offer rapid access to a senior clinical decision maker -
  - optimising digital health where possible in this clinical consultation and signposting to available local services, such as Minor Injury Unit (MIU), AEC, and ED if required
  - if a face to face consultation is required offering an appointment to be seen

10.16.3. This has been delivered within the context of NHS Borders's Reshaping Urgent Care Project and the CHAC model was further developed.

10.16.4. A further local review of the service is planned to take place at the end of the winter and actions envisaged include:

- Further development of the existing pathways including interfacing with key services incorporating locality based services
- ED scheduling through Borders Urgent Care Centre
- Development of Ambulatory care services to include Surgical, Care of the elderly (frailty) & Respiratory specialties
- Tests of change using 'NEAR ME' with SDM and other care providers in the BUCC
- Local communication & public education to reduce self presentations to ED

10.17. **Care Homes**

10.17.1. A lead nurse has been appointed for care homes and work is underway to appoint to further roles in support of care homes, these include education and infection control. We have an established operational and strategic oversight group with strong partnership with SBC and Community Care Home Review Team (CCRT). Assurance visits to all care homes have been completed and further program of visits is planned. We have daily oversight of care homes via the Turas monitoring system and any anomalies or concerns are followed up. The District Nursing teams can be mobilised at any point to support care homes.

10.18. **Patient Safety**

10.18.1. A core feature of the Primary and Community Services remobilisation plan is the specific clinical prioritisation of service groups; feeding into the overarching NHS Board's clinical prioritisation group to enable a consistent approach to ensuring treatment decisions are balanced with the risk of COVID-19. Fundamentally this will involve the review of the management and streaming of patients back into safe services.

10.18.2. Risks to ensuring the safe delivery of services continue to be discussed at the Primary and Community Services COVID-19 Silver meeting, and are escalated to the organisational COVID-19 Gold meeting. Established safety processes such as the daily Community Hospital Safety Huddle are used to ensure COVID-19 related safety issues, such as access to PPE, are highlighted and addressed quickly. Additionally the COVID-19 Risk Register continues to be reviewed by the Primary and Community Services Quadrumvirate and risks discussed at the organisation's Risk Management Board and Occupational Health and Safety Meetings. A number of actions have been undertaken to ensure staff safety, whether this is proactive review of appropriate PPE use by our Infection Control team and nurse leadership, or the programme of activities working to increase social distancing in the workplace.

10.18.3. Within Primary and Community Services we have worked in conjunction with our mental health colleagues to develop the 'Renew' service providing support to patients presenting with mental distress to GP practices during the pandemic utilising Action 15 and Primary Care Improvement Plan (PCIP) funding.

10.18.4. MIU are not currently open across our community hospitals; the provision of these services is being considered within the context of our work on Transforming Urgent care, 111, Community Treatment and Care services and the use of Near Me, in order to provide safe scheduled access to minor injuries services where possible.

10.18.5. Across our community teams, we are looking at how to maintain effective service provision and also clear any existing backlog which has resulted from pandemic prioritisation. Primary and Community Services continue to utilise digital resource such as Near Me to facilitate appointments and are assessing clinic space in order to support face to face consultation demand. The staffing structure of our community teams are frequently reviewed to meet the demands of realigning patient pathways, which also includes the potential to bring back repatriated staff to their core service.

10.19. **Delivering High Quality Care within Primary & Community Services**

10.19.1. During the response phase to COVID-19 within the range of nursing services in the community (including community nursing teams, treatment rooms, health visiting, sexual health and school nursing services) we initiated a locality based triage service. This enabled patients who required access to care to speak with a clinician to establish what support was needed and risk assess the most appropriate staff member and site to access this care. This may be within a treatment room, clinic area or patients own home. Individualised assessments to establish the wellbeing of the patients prior to visits were established.

10.19.2. Locality huddles were implemented to coordinate a patient focused approach to care. This included health and social care working in partnership to ensure through a locality approach that vulnerable patient groups were supported, driving discharges forward and ensuring safe staffing levels across the teams. This enabled health and social care colleagues to share the areas of concern and work together to address these issues.

10.19.3. Collaborative working between Home First, Marie Curie, District Nursing and Palliative Care has strengthened patient support for end of life care within the patient's own home which has ensured that patient wishes were being met. Initial discussions have been held at our Clinical Interface Group on considering the need to strategically prioritise palliative care with joint working across the system.

10.19.4. Out of hours community nursing was delivered in partnership with Borders Emergency Care Service (BECS) which maintained the availability of nursing support in the out of hours period. This has improved team working and reducing lone working risks out of hours.

10.19.5. Community inpatient units benefit from the use of the excellence in care 'Care Assurance Information Resource' (CAIR) dashboard and the reintroduction of the local Senior Charge Nurse Quality dashboard containing a wider set of measures which enables the assessment

of performance against key quality standards. Inpatient areas audit infection control practice.

Remobilisation of Acute Services

11. **Introduction**

11.1. NHS Borders Acute Services has met unprecedented levels of challenge and activity over the last 12 months. The initial spring wave and then second larger COVID-19 wave required innovation, flexibility leadership. Services have had to innovate and workforce models have shifted rapidly to ensure safe and sustainable service. This experience has enabled changes that would usually take years; teams have developed a hospital-wide perspective, staff resilience has been built through meeting shared challenges, and responding to the requirement for rapid change is now considered business-as-usual. Assets have been developed that will prove critical in this next phase of our pandemic recovery.

11.2. There are clear priorities for Acute Services in the next stage:

- Rebuild and redesign our emergency and urgent care services
- The safe management of the backlog in routine elective care
- Continue to be able to respond quickly and in a planned fashion to COVID-19
- Support our staff to recover from the challenges they've faced in the previous year.

11.3. How these priorities will be approached will be described through the following sections of the plan.

11.1. **Safe and Prioritised Remobilisation /Expansion of Non COVID-19 Planned and Routine Care**

11.1.1 NHS Borders resumed routine outpatients and elective operating during August 2020. While this was subsequently paused in December in response to a second peak in COVID-19 activity, we would anticipate a second elective restart at the beginning of March 2021 to activity level achieved during our initial remobilisation.

11.1.2. Due to the restrictions on patient footfall in order to:

- maintain required social distancing,
- allow for the appropriate segregation of elective patients at all times,
- facilitate to appropriate enhanced cleaning of rooms and equipment,
- allow for the appropriate use protective equipment,
- reflect the limitation of our existing capital infrastructure;

11.1.3. Activity levels delivered during our initial remobilisation efforts have been limited to between **40-60%** of baseline (pre-pandemic) capacity.

11.1.4. In the interim and given limited capacity, NHS Borders has ensured that available capacity is being targeted to those patients in the greatest need. Our medical and nursing teams are routinely screening patients on waiting lists and prioritising according to the National Framework for Clinical Prioritisation issued in November 2020. This ensures that patients requiring urgent assessment or treatment are clearly identified and prioritised accordingly.

11.1.5. A Clinical Prioritisation Group has been established, this is a clinically led group and meets on a weekly basis to review available capacity and prioritised waiting lists to ensure that guidance is being applied consistently, and that capacity used to best effect. Our weekly reporting and performance framework has also been recalibrated to ensure we are focused on urgent waiting times, in addition to the other agreed national targets.

11.1.6. All urgent and cancer patients are afforded the highest priority and remains NHS Borders committed to ensuring that every effort is made to maintain both the 31 day diagnostic, and 62 day treatment standards for cancer patients. We has protected both urgent and cancer pathways throughout the period of the pandemic and are reporting no backlog activity for cancer services.

11.1.7. In addition, given increasing waits for patients referred for routine or non-urgent assessment or treatment, NHS Borders is reviewing arrangements for the active management and communication with patients on waiting lists. This is to ensure that those waiting understand their prioritisation, and are clear on how to communicate changes in their circumstances or clinical condition.

11.1.8. As a system and in line with national guidance we are working towards delivering pre-COVID-19 activity levels by Quarter 3 (October 2021). However, our ability to do this is dependent on current capacity restrictions being lifted, specifically those related to the segregation of capacity to COVID-19 and non-COVID-19 pathways, and social distancing measures. If measures are maintained then pre-COVID-19 activity levels will not be possible without significant additional investment in capacity.

11.1.9. As directed by the Scottish Government, NHS Borders invested recurrently in a number of posts to increase baseline activity levels on a recurring basis. Appointment were made during 2019/20 and amounted to a recurring investment from waiting times of £1.6m NHS Borders will require this level of funding to be made available from the Access Management Support Team in 2021/22 in order to reach pre-COVID-19 activity. We have assumed funding in our baseline activity assumptions.

11.1.10. NHS Borders will submit waiting times trajectories in April as per Scottish Government Guidance. This submission will detail activity both core and backlog and the assumptions that these trajectories are based on.

11.1.11. NHS Borders Financial Plan does not include any waiting times funding assumptions other than the £1.6million noted above. Any additional funding required to address waiting times as per the trajectories submitted in April, will be discussed with the Access Team as part of the review process.

11.2. Management plan for the backlog of patients waiting for planned care

11.2.1. In all clinical specialties numbers on routine outpatient, TTG and Diagnostics waiting lists have increased significantly due to COVID-19 and the associated reduction in capacity. We are working on the assumption that our core capacity will be remobilised to 100% of pre-COVID-19 levels from October, but this is dependent on the lifting of current COVID-19 restrictions to allow this to happen.

11.2.2. The following sections describe some of the improvement / new initiatives that we intend to progress to both create further capacity and improve service productivity. However, we can predict that capacity recovered from implementing and then sustaining these initiatives will not be at a level sufficient to address any of the waiting times backlogs we will have been building up to 30 September 2021. NHS Borders does not have the financial resources, staffing or infrastructure to address projected waiting times backlogs during 2021/22. It should also be noted that the size of projected backlogs, particularly for elective surgery, suggests that addressing these backlogs will take a number planning cycles and is dependent on the careful management and co-ordination of all available capacity (both NHS and independent sector) to ensure access is equitable at a national level. In many instances our rate limiting factor will be capacity based, and to some extent independent of available resources, certainly in the short to medium term.

11.2.3. We have received notification that NHS Borders has been allocated capacity at the National Golden Jubilee Hospital in Orthopaedics and Ophthalmology. Whilst we are keen to take up this offer of additional capacity, this will be dependent on the level of funding provided by Scottish Government and the clinical prioritisation of activity in relation to funding levels provided. Until we receive clarification we are not intending to include the benefit of Golden Jubilee capacity in our projections.

11.2.4. As has been described in the previous section, efforts will be focussed on ensuring safe clinical prioritisation. This will require proactive communication with patients to ensure expectations are managed carefully, and these are updated in line with any additional capacity agreed that will change expected waits. Work will be undertaken with our clinical teams to ensure consistent clinical prioritisation is maintained, and to seek innovative ways to better manage service demand, and on ways to identify and remove inefficiency and waste.

11.2.5. In addition to backlogs of those patients referred for their first appointment, we also have a high number of patients overdue a review appointment. This is particularly relevant for those patient diagnosed with a long-term condition. Patients on these review lists with chronic conditions run a high risk of harm if not regularly seen where this is clinically necessary. We also have a number of surveillance waiting lists that were suspended during our initial COVID-19 response and will require additional time and resource to address. We will be working with specialties concerned to explore these issues and identify appropriate solutions based on appropriate clinical priorities. It is worth noting that in doing this we may find capacity for new outpatients or TTG waits diverted to review or surveillance activity based on an assessment of priority at a service level. This will be identified as part of April trajectories.

11.3. **Patient and Staff Safety**

11.3.1. Within the BGH planned 'green' elective patients are admitted into our 'green' routine surgical ward. Patients undertaking routine operations are COVID-19 screened prior to admission and are protected from other patient groups Established safety processes such as the daily hospital Safety Huddle are used to ensure COVID-19 related safety issues, such as access to PPE, are highlighted and addressed quickly. A number of actions have been taken to ensure staff safety, whether this is proactive review of appropriate PPE use by our Infection Control team and nurse leadership, or the programme of activities working to increase social distancing in the workplace.

11.3.2. The Emergency department has extended their footprint to allow safe placement of patients through a single point of assessment and triage to allow full utilisation and flexibility across all cubicles. This increases the availability of cubicles at peak teams of activity, therefore keeping patients and staff safe with appropriate infection prevention control precautions in place.

11.3.3. Procedures have had to be instigated in theatres for Aerosol Generating Procedures and donning and doffing PPE which reduce our efficiency in theatres by about 20-30%. These measures impact on our through put and will be built into the recovery planning assumptions.

11.3.4. NHS Borders has established an integrated hub which assesses delayed discharges to enable patients to be cared for in the right environment.

11.3.5. COVID-19 Health & Safety Checklists have been undertaken by all services to ensure consistent safe processes and practices exist across all of Acute Services. These checklists ensure all areas have appropriate signage, social distancing and robust Infection Control practice.

11.4. **Management of Delayed Discharges**

11.4.1. Processes and relationships developed to actively manage delayed discharges through 2019/20 will be built on. The Integrated Huddle meetings will be extended to cover more of the system to ensure safe patient flow. The new weekly Delayed Discharge meeting will increase scrutiny of delayed pathways to reduce bed days associated. The strong whole-system team-working that characterised the winter period, where pathways were adapted operationally to reduce pressure in the BGH, will shift its focus to medium and long term planning. A shared approach is evolving between Acute, Primary/Community and Social Care, to reduce delays in transfer of patient care through greater in-reach, new cross-service multi-disciplinary teams and using technology to reduce variation in patient pathways. Developments such as Discharge to Assess, STRATA and the expansion of Home First will be critical.

11.4.2. Specifically in Acute, once COVID-19 response measures are relaxed, the hospital aims to restart the Older Person's Assessment Area (OPAA) trialled in early 2019 and paused due to COVID-19. There is also an appetite to expand the new Borders Urgent Care Centre (BUCC) to provide further alternatives to the emergency department and support the

avoidance of unnecessary admissions. Finally, Acute Services are motivated to explore increasing the provision of geriatric expertise in the community.

11.5. **The Unscheduled Care Team**

11.5.1. The recent reduction in COVID-19 activity in the hospital has allowed 'winter' medical inpatient capacity to be re-opened. If this capacity can be maintained then the next key step will be the removal of GP assessment activity from the ED through the relocation of the Gynae and Surgical Assessment Unit (GSAU) and Acute Assessment Unit (AAU). The removal of GSAU is dependent on recruitment and an adapted COVID-19 safe service model. Moving AAU is likely to take a longer period with delivery during the second half of 21/22.

11.5.2. As part of their escalation process for COVID-19 and to ensure compliance with social distancing and infection prevention Control standards the ED is still working out of an extended footprint. The single point of triage model continues to work well and to ensure patients are placed on the right pathway for their care needs early in their journey. A negative pressure pod has been installed in the ED to safely deliver any Aerosol Generating Procedures in acute emergency care.

11.5.3. As we move to the 'new business as usual model' a key priority will be a review of the ED workforce as well as the environment including capital works. The review will align with the learning and developments of the Redesigning Urgent Care project where we are aiming to reduce self presentations to the ED as well as signposting patients to the appropriate pathway in a scheduled approach.

11.5.4. Further activities planned to improve EAS performance include process improvement work in the Medical Assessment Unit (MAU), re-starting the ward discharge work paused in December and building on the weekly EAS clinical engagement meetings to ensure whole-system ownership of flow.

11.6. **Redesign of Urgent Care**

11.6.1. The Flow Navigation centre (Borders Urgent Care Centre – BUCC) went live on the 1st December 2020 and the dispositions include scheduled appointments to a Minor Injuries service, medical ambulatory care and to the ED. We are working with our local mental health crisis team to develop scheduled appointments within ambulatory care. Further Developments planned for 2021/22 include strengthening the local interface with primary care, access to local community treatment rooms, scheduled ambulatory appointments with the Respiratory specialist team, direct referral to the community pharmacists, a referral pathway from the SAS and a new frailty pathway.

11.6.2. National funding to continue the BUCC has been assumed in our plans for 2021/22. Should funding not be provided then plans to revisit the BUCC will progress through early 2021/22.

11.7. **Outpatients**

11.7.1. In October we returned to 60% of our pre-COVID-19 outpatient activity. This is split 40% virtual (telephone and Near Me) and 60% face to face consultations. Our approach will be

similar during Q1 and Q2 in 2021. For those patients who require a face to face appointment in the acute service, standard operating procedures have been agreed to provide and maintain a COVID-19 safe environment and the safety of both patients and staff. Virtual consultations (Near Me and Telephone) will continue to be maximised where clinically appropriate.

11.7.2. In addition to Near Me technology, other opportunities for innovative technological solutions are being explored by a number of clinical teams. Linking in with the National Team we are looking at introducing asynchronous reviews where possible, and in a number of areas electronic photo triage to aid remote prioritisation and assessment.

11.7.3. All specialties are undertaking enhanced administration and validation of waiting lists to ensure patients are correctly placed on waiting lists and prioritised appropriately. This will be a continuous process for new, review and surveillance waiting lists.

11.7.4. We will be identifying capacity to review patient pathways, ensuring we are delivering the care by the right person at the right time, and avoiding unnecessary appointments whilst still managing patients safely. We will be working closely with our primary care colleagues through our Clinical Interface Group to achieve a joint understanding on the capability of each part of the system and to support the development of improved pathways.

11.7.5. For patients referred into acute care, Active Clinical Referral Triage (ACRT) sessions will be ring-fenced to ensure patients are placed on the appropriate pathways and specialties will work with patients to encourage self-management where possible.

11.7.6. New initiatives to manage demand and create additional capacity will continue to be explored to help address a proportion of the backlogs across all specialties. Our services will be harnessing the initiatives endorsed by the Scottish Access Collaborative; services have partially implemented these and we will aim to robustly implement Opt In, ACRT and PIR in all areas during 2021. Ophthalmology will be further promoting and optimising the Shared Care Service as well as converting more appointments to virtual only. The service will look to review all their pathways along with community services, which will include referral criteria, pathways and Post Infection Review (PIR).

11.7.7. We are continuing to explore new models of care within outpatient settings. For example our orthopaedic team are looking at the potential to convert a number of minor surgical procedures onto a day procedure/outpatient pathways under local anaesthetic. The potential impact this may have on service efficiency and productivity will be explored during 2021/22.

11.8. **Diagnostics**

11.8.1. <u>Radiology</u>

11.8.2 Initial projections for the remobilisation of routine imaging in CT and MRI suggested we could anticipate a significant deterioration is our reported performance. This was related to the capacity impact of COVID-19 secure measures on operational efficiency (i.e. a projected 20-30% reduction), and an expectation that we would see demand consistent

with pre-COVID-19 levels. In practice we have seen actual demand over the past six months consistently 20-30% below pre-COVID-19 levels across our 4 key diagnostic tests.

11.8.3. This reduction is likely to be a direct reflection of outpatient activity, and activity in general over this period, and it would seem safe to assume that we are likely to see demand at this level until outpatient activity, and activity overall returns to pre-COVID-19 levels. This would suggest that based on current demand and activity projections we should be able to maintain our current reported performance until COVID-19 restrictions are lifted, at which point we should anticipate demand and activity levels returning to pre-COVID-19 levels. There is some risk of residual demand putting pressure on waits but this is difficult to predict with any confidence. We will keep monthly demand/activity levels under close observation and respond accordingly.

11.8.4. However, NHS Borders needs to replace its current MRI scanner during 2021/22. While a replacement scanner has been purchased, replacing our existing scanner will require a mobile MRI unit to be on site during the anticipated 3 month capital replacement programme. The capacity of a mobile unit is not the same as current equipment and as a consequence we can anticipate a significant increase in MRI waiting times as a consequence.

11.8.5 Overlapping a mobile unit prior to, and following the replacement programme, would mitigate the potential impact of lost capacity. NHS Borders will seek funding from Scottish Government to support this approach. Based on having a mobile unit available on site for a period of 5-6 months, the projected cost would be an estimated £500k, and this would ensure our current MRI position is maintained during 2021/22.

11.8.6. The backlog projected in ultrasound capacity reflects vacancies at a Consultant level. These will in part be addressed with planned recruitment during the first half of 2021, and we are confident that we will maintain, and then from October 2021 address the backlog we are currently reporting as posts are filled.

11.9. <u>Endoscopy</u>

11.9.1. Alternatives to Endoscopic procedures have gained significant traction and momentum during our COVID-19 response. Our Nurse Endoscopist now does monthly cytosponge lists for Barrett's surveillance. The next phase will involve training additional staff to do cytosponge, thus releasing senior staff and capacity within our endoscopy unit. Last year we also changed our coeliac disease pathway and included the potential for a non-biopsy diagnosis in this patient group. This protocol has reduced the endoscopy requests generated from positive coeliac serology to 50% of previous levels.

11.9.2. We are also working closely with the national team to implement colon capsule to help meet demand for new and surveillance colonoscopy workload. The significant pause in bowel screening during our initial COVID-19 response is likely to increase referrals during 2021/22 for the colon service, and we will need additional capacity colon capsule offer in order to meeting higher expected demand, while maintaining waiting times within the agreed standard.

11.9.3 We will be reviewing the placement of our Cystoscopy Service; currently this is proved within our Endoscopy Unit. We explored the potential for this service to be provided in our outpatient department during 2020/21 which has worked well. Consideration of permanently relocating cystoscopy will be progressed during this year which in turn will create physical capacity for additional endoscopy lists. This relies on the Board receiving the core recurring funding as previously discussed with the Access Support Team.

11.10. Physiological Measurement

11.10.1. Currently Physiological Measurement and associated diagnostic tests are not included in national waiting time's submissions. However, due to significant capacity issues during 2021, NHS Borders has developed long waits for echocardiography and 24 hours tapes. These carry a significant risk. NHS Borders will in the waiting times submission in April' detail the current waiting times position along with a trajectory until March 2022.

11.11. **Cancer Services**

11.11.1. NHS Borders have prioritised Cancer treatments throughout the period of our pandemic response. This has allowed us to maintain levels of performance in relation to targets for both diagnostic and treatment pathways for cancer patients and we have no activity backlog in Cancer diagnostic or treatment surgery.

11.11.2. A focus on the appropriate clinical prioritisation of cancer related activity in outpatients, radiology, diagnostics services, and surgical pathways has ensured that urgent waiting times have been maintained within agreed parameters. We will continue to ensure that cancer remains our highest priority as we move into the next phase of our remobilisation.

11.11.3. Our cancer teams have worked hard to establishing a COVID-19 secure area with the hospital for the safe delivery of chemotherapy and associated treatments (SACT) to some of our most vulnerable patients. We are undertaking routine non-symptomatic screening of staff working in the cancer unit and have restricted non-essential footfall to a minimum. We have also reviewed both PPE and cleaning regimes to ensure that our patients feel secure and are comfortable attending for their treatments. This has been achieved without reducing operational capacity within the unit.

11.11.4. We will continue to work closely with our regional cancer partners to ensure that available resource and capacity is being used effectively across the region, and an equitable position is being maintained between Boards in terms of access to cancer care. NHS Borders has received support in Breast Surgery recently which suggests that arrangements for mutual aid are working effectively across the South East of Scotland. The regional cancer leads are continuing to meet on a monthly basis to discuss respective cancer positions, and opportunities for collaboration where support or assistance may be required.

11.11.5. We have recently appointed a Cancer Transformation Manager with the support of our Regional Planning Group. Working closely with colleagues across the South East network this post will support the development of a strategic gap analysis for cancer services within the region in line with planned investment and the National Cancer plan.

11.12. **Elective Surgery including Clinical Prioritisation**

11.12.1. The Surgical Clinical Prioritisation Group (SCPG) as referenced above has been formed to direct the allocation of elective surgical sessions to each speciality. The CPG is a multidisciplinary group comprising a chair (Anaesthetist), surgical leads, service managers, nursing managers for theatres and wards and booking staff. The group has terms of reference and a governance structure.

11.12.2. The aim is to ensure equity of provision of surgical services for patients of NHS Borders. The basis for this is as follows:

- NHS Borders must be able to accommodate P2 patients within the 1 month time threshold
- All surgical specialities should have equity of access to operating theatres for patients of the same prioritisation category
- The prioritisation framework and definitions as set out in the SG Cancer Framework (as used by FSSA and RSCEng) have been adopted
- Prioritisation for surgery should be based upon need, and therefore level of urgency of surgery. Prioritisation should be based on objective criteria, and should be based on national criteria or guidelines published by national bodies where possible
- There must be a mechanism for expediting or escalating patients from a lower prioritisation category to a higher one (e.g. P3 to P2, or P4 to P3), and this must be based on patient-centred criteria. Patients should not be expedited solely because of time waited for surgery.
- There should be objectivity in these patient centred criteria. The group has created a novel prioritisation matrix based upon the one used by clinical governance to help guide clinicians about how to prioritise or escalate patients' priority status based upon patient centred factors such as pain, immobility, loss of function etc.

11.12.3. Following the first COVID-19 wave, elective surgical services resumed on 31st August 2020. Due to staffing constraints associated with the creation of new 'green' pathways across inpatients and theatres, and a requirement to support staffing for COVID-19 response services such as Contact Tracing, theatre capacity was significantly reduced. The CPG ensured that each speciality was given adequate theatre space for their needs, and this was done by setting the rules by which Central Booking scheduled the lists and patients. Dashboards are used up to measure waiting list sizes for each speciality, and calculate waiting list times based on current throughput of cases. Sessions are reallocated from one speciality to another when need increases, based on factors such as a rapid increase in waiting list size or an increase in the number of P2 cases listed for surgery.

11.12.4. During the second COVID-19 wave, again elective activity was reduced to one 'vertical booking' elective list per day (10 sessions per week). Theatres will revert to 20 sessions per week as soon as COVID-19 activity allows, currently anticipated to be early March 2021. Routine surgery will be remobilised to levels similar to the remobilisation in autumn 2021 due to the same constraints (described above). There is a planning assumption that we shall return to pre-pandemic levels of surgery by October. This would require all COVID-19 processes that impact on capacity to be removed, including the 'green' elective ward and

theatre pathways. There may be an issue with accumulated annual leave from 2019/20 which may restrict the Boards ability to remobilise to a level similar to autumn 2021.

11.12.5. The resource implication of the requirement to provide a separate "green" pathway for elective patients has been an increase in ward specific staffing costs equivalent to £250k for the first 6 months of 2021/22, and a loss of 10 operating sessions in order to staff separate "green" PACU/High dependency areas for patients requiring higher observation post operatively. In addition, post anaesthetic recovery arrangements have reduced intra operative efficient but up to 20% on some higher volume lists. We will be working to improve efficiency during the 2021/22 or until such time as COVID-19 restrictions are lifted.

11.13. **Paediatric Team**

11.13.1. The focus of the paediatric team is to re-establish all services to be delivered to a similar level previously seen. There will be continued use of digital health technology such as Near Me and MS Teams to support this delivery to ensure that there if efficient use of all resources to support the care of all our patients. It is likely this will not be fully possible until COVID-19 Infection Control processes are removed.

11.13.2. A new consultant staff member will join the team in February 2021. This will strengthen capacity for specialist work.

11.13.3. Our acute services will continue to be delivered from ward 15 and special care baby unit to provide care to those acutely ill and this will continue to promote early discharge home. Ward 15 will continue to keep its average length of stay to below 0.8 days. Our community and specialist children's nursing team will support care at home with continued assessment of jaundiced babies at home as well as other innovations that will develop over this time.

11.13.4. Newborn hearing screening programme will continue throughout this period alongside other screening programmes. There will be staff changes in the coming year due to retiral's within the team.

11.13.5. Similar to all elective services, waiting lists within the service for medical paediatric outpatient assessment and paediatric surgical interventions have grown and clinical prioritisation has become a core focus. There is an appetite to address backlog and this is considered in the waiting times section of the plan. Use of digital health technology will be used to support this capacity where appropriate.

11.13.6. The Borders Urgent Care Centre (BUCC) now provides a hub to coordinate urgent care of patients with a focus on reducing the footfall into ED. The paediatric pathways need to be reviewed and scrutinised to reflect the services in NHS Borders to ensure a robust and safe service is provided for our paediatric population. We will review these pathways with BUCC colleagues.

11.13.7. SCBU will seek to attain UNICEF baby friendly accreditation that had previously been started.

11.13.8. The paediatric service will seek approval from the organisation to complete the service review that was commenced prior to COVID-19 response during 2020. This service review

will seek to use data to inform and shape our services going forwards so that our paediatric service is responsive and reflective of the service needs providing a safe, effective and financially resourced service model going forwards.

11.14. **Maternity Team**

11.14.1 The Maternity team has seen many changes occur within services during the pandemic response. Our aim is now to return to our new normal to react to the demands of our current patient population.

11.14.2. The antenatal and postnatal ward was relocated during the initial pandemic. Within our recovery plan it was highlighted that our inpatient capacity could be managed within a smaller ward area due to new ways of working. Ward 16 was identified and our service moved on 6th July 2020 for the short-medium term. During this time new ways of working has occurred enabling Labour Ward to provide Labour, Delivery, Recovery and Postnatal Care as the 'normal' for low risk deliveries. We have embedded Enhanced Recovery following Caesarean Section (ERAS), which means discharge occurs 24 hours following EL/LUSCS when clinically indicated.

11.14.3. Pregnancy Assessment Unit (PAU) has been relocated during the Pandemic and their present location is within Galashiels. The service has worked well and there is acknowledgement that this service does not require an inpatient facility. Therefore, the focus is for this service to remain within the Community setting.

11.14.4. Home births were re-introduced in June 2020 and we are working closely with the Heads of Midwifery Nationally, adhering to Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) guidance to re-introduce our care pathways for antenatal and postnatal care within the Community. Near Me was implemented to Community Midwifery from November 2020, which enables a face to face virtual booking appointment. This service has already been utilised for Consultant clinics when clinically indicated.

11.14.5. To reduce triage admissions to the acute hospital and to comply with Best Start recommendations, the clinical manager is working closely with the Senior Charge Midwives to devise triage pathways for the Community setting, ensuring patient safety is our number one priority.

11.14.6. During COVID-19, we have continued to deliver person centred care, working in partnership with Maternity & Children Quality Improvement Collaborative (MCQIC) to maintain our patient safety measures and in December 2020 we achieved UNICEF Baby Friendly Initiative Gold Award. This award has recognised the Maternity Service has continued to provide excellence in care and has demonstrated through leadership that we have a positive culture and innovative system and processes.

11.14.7. Within our service, planning for Beststart will recommence from March 2021 and the service will focus on achieving better outcomes for women, their babies and families.

11.15. **Delivering High Quality Care**

11.15.1 A new Adult Unitary Patient Record (AUPR) previously tested following staff consultation and developed using Quality Improvement (QI) methodology was introduced across the Acute and Community Care settings. This facilitates a person centred approach to assessment by clear information gathering of the patient outside of the care environment, care requirements, anticipatory care planning as appropriate and choices/preferences on care options.

11.15.2. Care Assurance to provide Senior Charge Nurses, Clinical Nurse Managers, Associate Nurse Director and the Director of Nursing assurance of the delivery of quality care and identify areas for focus and improvement is also being addressed in a different way using learning from the pandemic experience. Weekly Audits are currently being carried out across the Acute site by Quality Improvement Facilitator, outcome charts and summaries of learning identified are produced for circulation amongst Clinical Nurse Managers and Senior Charge Nurses who will develop a process to address the issues highlighted.

Mental Health and Learning Disability Services

12. **Introduction**

12.1. The Mental Health and Learning Disability Board have taken into account the Coronavirus (COVID-19): *Mental Health - Transition and Recovery Plan*, published on 8 October, to ascertain our ongoing response to the pandemic in terms of delivery of mental health services to the Borders population.

12.2. Mental Health services are a combination of integrated inpatient and community services covering a diverse portfolio of clinical specialties. The Learning Disability Service is an integrated community service and whilst referenced in our plan the Scottish Borders Council Remobilisation Plan will contain greater detail in relation to this service.

12.1. **Inpatient Wards**

12.1.1. Mental health inpatient wards have continued to function as normal throughout the pandemic. We have no identified COVID-19 ward therefore within each ward we have identified areas that we can use should a patient need to be admitted with COVID-19. Each ward also has a standard operating procedure for the management of suspected or confirmed cases of COVID-19 and inpatients have individual rooms. During the first wave, we moved our older adult functional patients into our acute unit to allow surge bed capacity for the acute hospital, this was done for 5 weeks and the patients were moved back. During the five weeks it did not have an effect on capacity for the age group. This was not done during the second wave.

12.1.2. During the second wave of COVID-19 the wards have continued to be under pressure with acuity however they have managed with contingency plans in place. We have recruited to additional staffing for 12 months which will allow us to have flexibility with staffing should demand increase across the service following lock down. This will allow a risk assessment of staffing establishments and ensure we can deploy staffing to areas of need.

12.1.3. The occupancy within our acute adult inpatient unit has increased during the pandemic therefore have increased the staffing on the unit, including dedicated consultant and junior medical time, and ensured the SCN was supervisory to ensure flow within the unit as we don't have any surge beds for acute mental health patients within NHS Borders. We monitor the occupancy levels daily and ensure timely discharges. As we only have 19 beds our contingency plans come into play when we have 16 inpatients. The contingency plans include, consultant review of all patients, use of crisis team, and consider suitable transfers to rehab unit or functional older adults if safe to do so. Transfer between units is closely monitored due to infection control.

12.1.4. There have been improvements in delayed discharges in our Specialist Dementia Unit partly due to the dedicated social worker based in Borders Specialist Dementia Unit. A review of dedicated dementia care which saw the unit redesigned in 2019 has led to reduced occupancy levels. The redesigned pathways are being embedded, which include the Care Home and Community Hospital Assessment Team, use of specialist dementia beds in the community, improved communications between Health and Social Care regarding delayed discharges, and as above a dedicated social worker.

12.2. **Crisis Team**

12.2.1. In adult psychiatry crisis management has adapted to meet changed demand, support intervention at an earlier stage and governance arrangements have been strengthened, recognising these enhanced roles and demand.

12.2.2. The Mental Health Crisis Team/Liaison Team continues to work closely with Acute services to manage unscheduled Mental Health presentations at the BGH. Admissions to Mental Health inpatient wards have increased as have bed occupancy levels and acuity of needs, as referenced earlier. Discussions are underway in relation to contingencies for a continued enhanced demand up to and during the winter period through the winter planning board. Two additional sessions for liaison psychiatry has been agreed up until the 31st March 2021 and further consideration is required for on-going resource to retain this.

12.2.3. The way that people in the Borders access our Emergency Department has changed as part of Reshaping Urgent Care. Anyone who doesn't have a life threatening condition, who would have normally present at our ED, should now call NHS 24 instead on 111, whether it is day or night. NHS 24 will assess the patient over the phone and they will be able to signpost the patient to the most appropriate treatment. This means that we can keep patients safe and also avoid patients having to make any unnecessary trips to hospital. The Borders Crisis Team now triage all calls from Borders Emergency Care, Police and Scottish Ambulance Service to support this new way of working, allowing early access to Mental Health knowledge and expertise and reducing the need for presentation to ED for assessment. Additional staffing will be needed to ensure this development can be sustained. In-hours, there are added governance measures in place to support the management of patients in crisis.

12.2.4. Our current Distress Brief Intervention (DBI) service is a key strand to this approach and we are looking to invest further through action 15 monies as continued service development. We are examining how we can support frequent Mental Health attenders across primary

and secondary care where formulation and longer term support may be required to deliver sustainable change.

12.2.5. We continue to see an increase in demand both within the community and inpatient settings. Inpatient beds remain at a premium. The modelling to prepare for the potential demand outstripping our existing capacity is now complete and has provided insight as to how we would manage this. Further detail regarding the outcome of the modelling exercise can be provided if required.

12.3. **Community Services**

12.3.1. Community services continue to adopt a Red/Amber/Green (RAG) approach to clinical and risk management of their patients. The risk management includes the consideration and balance of infection risk inherent to both staff and patients of face to face contacts whether in clinical settings or the patient's home. Mitigation introduced as part of the RAG status includes telephone contact and the initialisation and escalation of Near Me video contacts with patients. In addition to the RAG status each patient is now triaged against the most effective way to continue their support through telephone contact/face-to-face in full PPE/Near Me video call.

12.3.2. A strategic approach has been taken to support the implementation of community assessment hubs/Near Me hubs in order to support patients classed as technology deprived in order to increase engagement with our health services.

12.3.3. Access to health premises across the Scottish Borders remains a challenge and NHS Borders continues to review all space across their health footprint. Engagement with our Scottish Borders Council colleagues continues to determine if access can be given relating to their premises, specifically for face to face appointments, however this also remains challenging. Community teams continue to operate a three tiered approach by offering Near Me, Telephone and face to face. However, a new project is underway to develop a suite of rooms for Mental Health services on our Galavale site. This will provide 7 single multi-function rooms for Near Me, telephone and urgent face to face consultations, a 'group' room, along with the 2 clinical rooms for Borders Addictions Service.

12.4. **Adult Community Mental Health Teams (CMHTs)**

12.4.1. The uptake of digital platform (Near Me) has been successful within this service, which has been essential in order to continue to deliver care and treatment. All 3 teams (East, South and West) have used the RAG approach and review patients on each individual current case load to ensure appropriate input is delivered. Care plans and risk assessments have been reviewed / updated as necessary and clinicians have worked with the MDT to prioritise patients requiring ongoing support. Face to face appointments are provided where clinically appropriate. Clinicians continue to provide mental health assessments / treatment. Emergency and Urgent patients continue to be seen within the recommended time scales**.**

12.4.2. We have limited clinical space to conduct face to face consultations however the space we do have access to has a full COVID-19 risk assessment with adherence to local and national

infection control guidelines and the appropriate use of PPE. This also includes the option at times of domiciliary visits with associated risk assessment pre-visit.

12.4.3. The West area has continued to develop a waiting list which has increased during the second wave of COVID-19, there are currently staff from the MDT reviewing this and making contact with patients. The waiting list for CPNs continues to be high. We are currently triaging this waiting list and are contacting all those waiting by telephone. This has been followed up with opt in letters for the people who we have been unable to make contact with 14 days to opt in, if they do not respond they would then be transferred back to primary care (GP) by letter. We have looked at RAG status and have managed to allocate a proportion of the most urgent to CPNs; there has been a reduction of a fifth. This will continue to be an ongoing process.

12.4.4. We have struggled to recruit into community nurse vacancies for two years. With a few exceptions vacancies have been filled internally which has a continual impact on different services within Mental Health. There have been several retirements in the last year and there is further staff on the verge of retirement. We have not been able to recruit to a development post as there were no applicants; this has now been advertised twice with no success. We plan to up skill the band 3 staff to support other clinicians in the delivery of patient care, ensuring supervision is provided. We foresee this having an impact on reducing the frequency of contact with CPN to patient. We are currently looking at securing band 6 posts within the teams due to high level acuity of patients.

12.4.5. It is worth noting that we have seen a significant increase in acuity in peoples illnesses, more psychosis episodes, detentions under the Mental Health Act and an increase in Perinatal referrals, this has an obvious impact on staff and their resilience/morale levels.

12.4.6. Currently on pause are Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD) assessments and we need to consider further review to determine if this will free up capacity for higher risk patients, and whether increasing the skill mix of the assessment pathway will also support. It is noticeable that there is a gap due to Gala Resource Centre being paused for group work/individual pieces of work and lack of functioning 3rd sector supports to refer on to.

12.4.7. **Plan for next year:**

- Perinatal - SG funding has been allocated for mental health nursing time, fixed term 2yrs (0.5) which we have successfully recruited back fill for in order to release existing nurses within the teams to establish a specific role for education/training/networking/expertise within all 3 teams to ensure continuity and consistency throughout the community. We aim for this work to start by April 2021. There is also one additional medical session which is being utilised to assess patients in the perinatal period across the geographical patch; this will be supported by the additional nursing time.
- Our Personality Disorder treatment pathway continues to be developed and we will work to complete and embed this within our services within the next 6 months.
- We continue to work with our regional partners to review and improve our local Eating Disorders pathway. A review of the pathway and provision of specialist psychological and dietician input two years after their introduction has been undertaken and presented to the MH senior management team in early February. The review set out the

general picture of increased referrals to adult MH services and admissions to the Borders General Hospital of those with Eating Disorder. Taken together with discussions at a regional level, the MH senior leadership team intend to support a local development plan of the whole pathway based on the findings and recommendations of that paper. It is anticipated there will be local implications for funding, line management, training and collaboration between facets of the service and with the Regional Eating Disorder Unit; the timescale for achieving those aims is likely therefore to be a further 12-18 months.

- The service will continue to consolidate practice and develop new and innovative ways to deliver patient care; this will include how scheduled services mobilise to 'receive' relevant unscheduled presentations in a timely way.

12.5. **Mental Health Older Adult Services (MHOAS)**

12.5.1. This service has experienced difficulties to continue to deliver care and treatment within the community to patients with cognitive deficits due to the poor uptake of consultations via digital platform, mainly due to either the patient/families not having access to technology and/or lack of ability in how to use this. Clinicians have continued to risk assess through RAG status and liaise with patients and families either by telephone or Near Me consultations where possible and if deemed clinically critical clinicians have been seeing patients face to face with appropriate Personal Protective Equipment (PPE) .

12.5.2. Waiting lists have increased to a level where if we continued not seeing face to face unless critical then this would lead to patients/carers reaching crisis point therefore risk assessments are carried out and if safe to do so clinicians will see face to face ensuring adhering to the (PPE) government guidelines. All clinicians that have face to face contact with patients are now self testing twice weekly and all have received their first COVID-19 vaccination; safety will be enhanced as the older population continues to be progressively vaccinated.

12.5.3. Due to Occupational Therapist's leaving the service this has left a significant gap however resources have been pulled together and there is a reduced service to ensure existing waiting list does not increase to an unmanageable level. Recruitment has been a challenge however we are progressing through this with some degree of success.

12.5.4. To ensure and maintain staff wellbeing, line managers are keeping in touch with staff on a mutually agreed basis by MS Teams. The team are also encouraged to have regular coffee catch ups on MS Teams to ensure that there is support on an informal basis for staff. Occupational Health are also available for support if required. Staff who are working on the duty cover rota are office based and this gives staff the opportunity to safely see colleagues on a face to face basis taking into account current government guidelines re COVID-19 safety.

12.5.6. Due to vacancies elsewhere within Mental Health services there will be further vacancies within the team and managers are working on solutions to address this.

12.5.7. **MHOAS – plan for next year:**

- Continue to deliver patient care and treatment in the community providing outreach to try to reduce hospital admissions where clinically appropriate.
- Look to review and embed systems and processes of work taking into account current approaches in the use of technology to streamline patient journey and ensuring most efficient use of clinical staff time. The review is currently ongoing and is continually changing.
- We are currently working together with Borders Carers Centre as we recognise the significant amount of stress that COVID-19 and the restrictions have placed on them, fortnightly meetings are in place so we will continue Mental Health representation within these.
- Respite options are currently being reviewed and we are working alongside SBC colleagues to ensure we have a joint approach. Completion date that is being worked towards is March 2021.
- The Infant Mental Health agenda will be progressed with 2 sessions of medical time dedicated to that.

12.6. **Care Home & Community Hospital Assessment Team (CHAT)**

12.6.1. This service has been running for 17 months, the initial aim was to prevent older people with dementia experiencing unnecessary moves of care provision as a result of untreated distress by improved detection, assessment and treatment of mental health conditions in care homes and community hospitals, initial data would suggest that the CHAT service has had a direct beneficial impact on the above. Since CHAT launched at the end of September 2019 there have been 3 admissions from Care Homes in 9 months = 0.33 admissions per month on average, prior to this there were 0.5 per month.

12.6.2. CHAT nurses continue to work alongside Care Homes/Community Hospitals by completing assessments and planning input from CHAT to support/review/assess and work along with staff to implement care planning to improve mental health, reduce stress and distress for patients by adopting the Newcastle model, increase staff confidence and knowledge relating to Mental Health and Dementia.

12.6.3. They are currently providing face to face with appropriate PPE equipment, telephone and Near Me contacts, and more intense and reactive service due to COVID-19. Limited full Newcastle model work due to restrictions and accessing care homes.

12.6.4. A further review of this service was planned for April 2021 however due to COVID-19 this has been postponed as current data collection would not provide a true reflection of the initial aim of the service.

12.6.5. All staff continue to get weekly COVID-19 testing and utilise self testing once weekly, all staff have had their first vaccine.

12.6.7. Staffing has at times been challenging and staff have been deployed on a temporary basis to ensure safe staffing levels within the Borders Specialist Dementia Unit.

12.6.8. Despite shielding the Occupational Therapist has taken on a very active role of duty person for CHAT to triage referrals, provide advice and support by telephone.

12.6.9. Due to both Psychologists leaving the service this has obviously left a gap within service provision; we have partially covered this by using resources from the Older Adult Service. We are in the process of recruiting to a Band 8a and 8b psychologist however we only anticipate these posts being filled from October 2021.

12.6.10. **CHAT – plan for next year:**

- Resume Newcastle model work in all areas if resources available to take this forward.
- Further work is required refining the robust outcomes and supporting data collection.
- Scoping options for expansion of the service including inpatient wards and community settings.
- Focus on developing/providing training within care homes. Work has commenced to identify the training needs of care homes and then once training needs are identified plan will implemented within the next 3 months.

12.6.11. This will be achieved by ensuring that there is a full working establishment and will also provide timely input and ongoing awareness of CHAT service.

12.7. **Post Diagnostic Support Service (PDS)**

12.7.1. Most of our contact with patients/carers/relatives is conducted by telephone at present. Near Me consultations are offered, but the uptake for this has been minimal (unable to use technology, no technology available, sensory impairments and stage of illness are all reasons given for not using Near Me).

12.7.2. It can be challenging for staff to build up a rapport with patients and their carers by telephone. People often have hearing impairments or their illness is more advanced and they struggle to manage phone calls.

12.7.3. Group sessions (Living with Dementia) are on hold at present, but have been adapted and can be delivered one-to-one using Near Me or by telephone, following information being posted out, but again dependant person to person. It has been particularly difficult to meet one of the 5 Pillars - Community Connections at present as all community based activities, groups and day centres are paused. There is a high proportion of staff shielding within this service leaving less than 1WTE Staff Nurse and 1.5WTE Health Care Support Worker able to carry out face to face consultations if required.

12.7.4. **PDS – plan for next year:**

- Within the next 6 months, we plan to continue to develop our PDS Service within the Borders.
- Plan to trial Dementia screening within a small GP practice within the Borders to assist with Early Diagnosis
- Continue to develop group sessions for patients with a Dementia diagnosis receiving PDS, within the Community. Timescales are difficult to predict due to the uncertainty given COVID-19.

- Continue to work with and develop our relationships with Health and Social Care and the 3rd Sector/commissioned services

12.8. **Children & Adolescent Mental Health Services (CAMHS)**

12.8.1. The service has used the RAG approach to review patients on the current case load and waiting list. Care plans and risk assessments have been reviewed and updated as necessary and clinicians have worked with the MDT to prioritise patients requiring ongoing support. Clinicians have implemented the digital platform Near Me for appointments with the families' agreement. Face to face appointments are provided where clinically appropriate. Clinicians continue to provide mental health and Neurodevelopmental (ND) assessments, treatment and review of children and young people. Progressing ND assessments with children and young people are discussed with the possible pause until routine face to face appointments are resumed unless there was a clinical need. Emergency and Urgent patients continue to be seen within the recommended time scales**.**

12.8.2. The ongoing Intensive Treatment Service has seen an increase rise over the past few months and clinicians work together with families to support children and young people to stay at home as an alternative to hospital admission where clinically appropriate.

12.8.3. A temporary Nurse Led Opt in Assessment appointment system has commenced since January 2021 to ensure that patients on the CAMHS RTT waiting list are offered an appointment, patient and family feedback is being gathered. This was implemented to fill the gap until the service is fully recruited. This includes both mood disorder (MD) and Neurodevelopmental (ND) referrals by treating in turn. There have been some workforce changes with staff leaving. CAMHS have recruited into 3 band 6 nursing vacancies and are waiting on start dates. Psychology posts should be filled by October 2021 and there is 1 locum Psychologist working remotely to support current psychology staffing challenges. The CAMHS Service Review has progressed well working alongside the Scottish Government, bench marking against the CAMHS Mental Health Standards other CAMHS in Scotland. Stakeholder, patients and families, staff opinions of the service were sought, data collected and the service has been working with the Senior Management Team in delivering on a service improvement plan which will be taken forward during 2021. Staff Wellbeing has been supported by the CAMHS Leads. A dedicated project manager for Mental Health has recently commenced post and is supporting the service in developing a robust programme plan with clear timescales for delivery. This plan can be shared once finalised.

12.8.4. **CAMHS plans for next year:**

- The development of the treatment pathways for mood disorders and Neurodevelopmental disorders
- Review the autism assessment and diagnosis process
- Increased patient / family and stakeholder involvement within the service including future developments
- Full comprehensive review of the Improvement Plan
- Reduce the RTT waiting list, including completing an engagement appointment test of change

12.9. **Community Rehab Team (CRT)**

12.9.1. During the pandemic the service has continued to deliver care and treatment within the community to patients with severe and enduring mental health problems. Patients are being seen face to face at home and treatment continues to be administered routinely due to the clinical need and legislative reasons. Clinicians adhere to instructions and follow infection control guidance in accordance to maintaining patient, family and clinician's safety. Clinicians have been innovative balancing seeing patients in their own homes and working from home. Clinicians continue to risk assess through RAG status and liaise with patients and families prior to appointments. Through nurses leaving the service and long term sickness a band 6 CPN has temporarily been deployed to CRT from the Community MH Team (CMHT) since November 2020 and will return to substantive position at the end of February 2021. Staff wellbeing is supported by the Leadership team; clinicians have 2 catch up meetings per week through MS Teams along with the Team Meeting. Supervision is in place and staff have access to the Occupational Health service.

12.9.2. There has been a pause on the annual physical health checks due to restricted access to community treatment rooms and GP practices.

12.9.3. **CRT plans for next year:**

- Undertake a Supported Living Proposal project involving patients and families, and all other related stakeholders.
- The service will continue to deliver patient care and treatment in the community providing outreach to try to reduce hospital admissions where clinically appropriate.
- The patients within the rehab service will be prioritised for the remobilisation of the physical healthcare agenda within Mental Health, supported by collaboration with Primary Care around Community Care and Treatment Centres.

12.10. **Borders Addictions Service (BAS)**

12.10.1. The Borders Addictions Service (BAS) have adjusted practice to continue to where clinically appropriate see patients face to face. BAS continue to meet the 3 week waiting times RTT currently with no waiting list. Ongoing substitute prescriptions and in-patient detoxifications continue as planned. The open case load is RAG risk assessed. The service have successfully worked with patients on completing full treatment programme of treating Hepatitis within the community and continue to deliver Naloxone training working closely with partner services. Buvidal treatment has been successfully introduced within the Borders with now 45 patients prescribed. There are no staffing issues within BAS. Efficient and effective joint working with partner services meeting regularly with ADP reporting on performance and service delivery. Staff are working between home and in the office where appropriate. Staff wellbeing is being supported by the Leads through catch up meetings over coffee, Team meeting and regular planned supervision.

12.10.2. **BAS plans for the next year:**

- Resume 'Drop In Hubs' within the towns of the Borders in line with Government COVID-19 guidance.

- Implement Trauma training awareness for clinicians, and support 2 nurses to complete Non Medical Prescribing training.
- Maintain and progress the national MAT standards.
- The perinatal Mental Health agenda will be progressed through an additional 2 sessions of consultant psychiatry time within BAS.

12.11. **Psychological Services**

12.11.1. Psychological services offer evidence based psychological treatment, consultation, supervision and training across mainly (although not exclusively) Mental Health and Learning Disability services.

12.11.2. We have worked closely with teams we are aligned to in Mental Health and Learning Disability following similar processes with completing RAG status of all our current patients and being prepared to offer back up to teams if necessary in relation to surge capacity.

12.11.3. The transition to Near Me has been particularly successful for psychological therapies offered in adult mental health settings with a high degree of acceptability from most of this patient group. Long waiting times continue to hinder our ability to offer quick access to psychological therapies and this has been hindered by delays in recruitment and maternity leave.

12.11.4. Our commitment to expanding access to psychological therapies will continue. The main development in this regard has been the collaboration between Mental Health, Psychological Services and the Primary Care Improvement Plan (PCIP) to establish the 'Renew' Primary Mental Health Service in October 2020. Offering mainly psychological therapies, this offers a see and treat model for mild to moderate mental health issues. We have brought our digital therapies into Renew to enable ease of access and will continue to widen the offerings of Silvercloud and Beating the Blues. We have been part of a test of change offering Leso, another form of digital therapy and are currently working on a test of change with Silvercloud offering digital treatment to children and young adults with anxiety.

12.11.5. Renew also offers two regular groups for anxiety and low mood. The Renew Service was established as a centralised service offering only remote interventions due to restrictions of COVID- 19, and we are due to review the first 6 months of operation in April 2021. To date though, there has been strong demand for the service and positive feedback from GP Practices.

12.11.6. The psychology services to Older Adults, Substance Misuse and Learning Disability have been considerably impacted due to COVID-19. Given these groups are often digitally disadvantaged and can have some physical health vulnerabilities, we have worked closely with services to try to offer psychological therapy where possible, but cognitive and neuropsychological testing has been severely impacted.

12.11.7. Our psychology service to CAMHS has had a challenging time in 2020 due to staff sickness and vacancies. However, our work with the Mental Health Division in the Scottish Government and NHS Borders initiatives are starting to yield a positive impact, and we

expect to be fully staffed in 2021. Having said this, we have operated at a highly reduced capacity for the last quarter of 2020 and expect to do so for the first quarter of 2021.

12.11.8. We have been working closely with occupational health and organisational development and have appointed a senior psychologist with Scottish Government/NES funding to offer highly specialised staff support.

12.11.9. We appointed a Psychological Trauma Co-ordinator in December 2020 who is currently working with Mental Health and NHS Borders leadership teams to consider positive actions we can take in order to become a more trauma informed organisation. Our Trauma Co-ordinator is also working with the local Healthcare and Forensic Medical Examination Services working group to improve services for survivors of rape and sexual abuse.

12.11.10. NHS Borders has been offered enhanced support from the Scottish Government Mental Health Division. Our head of psychological services is involved in these meetings as part of the Mental Health Quad Group, and a separate group has been established to review psychological therapies with the Scottish Government group which met on 8th February 2021. This work will continue throughout 2021/22 and future meetings are scheduled to take this forward.

12.11.11. Initial recommendations include developing a short, medium and longer term plan for psychological therapies that include waiting list management planning to deal with longest waits, a review of the psychology management structure, a review of psychology resource with a view to ensuring its optimal function and allocation and consideration of the way forward in terms of current gaps in resource which include clinical health psychology, neuropsychology, inpatient adult and older adult psychology.

12.11.12. We have been working hard with our Business Intelligence team on data quality, and plan to establish Mental Health dashboards including Psychological Therapies and 'Renew'.

12.11.13. For all NHS Borders clinical services, including Mental Health and Learning Disabilities, a Clinical Prioritisation Group has been established to support this strategic decision-making and ensure resources are allocated across the system based on clinical priority.

12.12. **Gala Resource Centre**

12.12.1. The Gala Resource Centre (GRC) is a joint partnership service between Scottish Borders Council and NHS Borders. GRC offers support to adults 18 and over with mental health difficulties, and provides centre and community based leisure, interest and skills based courses indoors and outdoors, where individuals can access support to regain and develop their existing skills, strengths and abilities.

12.12.2. Leading up to the outbreak of COVID-19 GRC was about to undergo a strategic review under Scottish Borders Council Fit for Future (FF2024) and Mental Health's Transformation programmes. However, as a result of the restrictions imposed by COVID-19 GRC moved to on line only service user contact and has had to close to new referrals. A review of caseloads is underway due to be completed by the middle of February 2021, ending input or redirecting service users where appropriate.

12.12.3. Due to the pressures staffing inpatient wards the Health component of the staff team has been largely redeployed leaving a minimum Health presence. Due to this redeployment of staff and the considerable reduction in open service users we have temporarily redeployed the remaining Day Centre Officer's (DCO's) and Peer Worker. The Local Area Coordination service (LACS) already provides community support to MH service users. We have assessed that the best use of 3 of the remaining staff will be achieved by temporarily redeploying them into the LACS and further discussions are required in relation to the Peer Worker. The existing LACS management team will line manage and allocate work to the DCO's. The DCO's and Peer Worker will be allocated work appropriate to their grade.

12.12.4. **GRC plan for the next year:**

- Review day centre provision under Fit for Future 2024 Scottish Borders Council and Mental health transformation plan

12.13. **Learning Disability Service**

12.13.1. Clinical views from services are indicating an overall increase in supportive measures being implemented to support people at home. Staff are reporting an increase in demand for mental health support to patients and we anticipate that this will continue. Learning Disability services are seeing an increase in demand for additional support due to buildings based Day Services remaining closed. There is an expectation that more buildings based Day Service space will open up in the short term but this will continue to be restricted due to the anticipation of infection control measures remaining in place. Respite services have been reduced due to the impact of COVID-19 and there continues to be an increased demand upon care at home resources. There is no local inpatient facility for Learning Disability other that Huntlyburn ward in which its criteria is mild to moderate with the predominant clinical presentation being that of a mental health disorder. We are seeing an increase in carer stress which is leading to a breakdown in normal social supports with additional support being provided to an already stretched Community Mental Health Team.

12.13.2. Scottish Borders Council have oversight of the remobilisation of Day Support and Respite/Short Breaks services.

12.13.3. We have planned the following workstreams over the coming 2 years:

- A review of Day Support for adults with learning disabilities will be taking place in 2021-22 with a focus on models of support in localities.
- We anticipate remobilising the Learning Disability access to Cancer Screening project later in 2021 which was suspended at the outbreak of COVID-19 in March 2020.
- QNIS funding has been achieved to focus on producing resources for adults with learning disabilities using maternity and parenting pathways.
- QNLD - we will move to first stage peer review in 2021 and create an action plan to meeting criteria.
- Inpatient beds - we have been working with NHS Lothian regarding access to two beds within their strategic plan. Currently, if learning disability hospital care and treatment is required, we continue to rely on primarily private, high cost, hospital placements across the UK. This presents us with challenges in monitoring the quality of care delivered and

is compounded by geographical distance which makes governance of these placements difficult to administer.

- Access to regular respite and short breaks continues to present us with challenges. We will build on the improvement work in 2019-20 to review the options available locally.
- Transitions – we will continue to scope demand via the learning disability tracking group 6 monthly and feed this information into our strategic planning processes and anticipate an increased demand for support from young people with increasingly complex support needs. We are working with children and families services and education using the Principles into Practice 3 framework to improve the transitions experience of young people and their families building on our pathway development and working with ARC Scotland and other areas across Scotland to share learning.
- Increase in complex needs coming to the service / people living longer with complexity of health, age, co-morbidity.
- Suitable residential accommodation for older adults with Learning Disabilities and dementia – we will be exploring the range of options available locally with a view to working with partners to scope out alternative options.
- LD Complex Care Unit – we have agreed an approach to move forward with NHS Borders, Scottish Borders Council and the Scottish Government and are presenting a paper in March 2021 to explore commissioning opportunities to provide suitable accommodation and support for adults with learning disabilities and additional complex support needs to return to Scottish Borders.
- Review of deaths – we have identified a small team to review a random sample of people who have died to gain lessons learned and areas of good practice or areas for development.

12.14. **Enhanced Improvement Support Programme**

12.14.1. In November 2020 NHS Borders was selected as one of the Boards to receive a tailored programme of enhanced improvement support from the Scottish Government. This programme of work commenced early 2021 and will have particular focus on remobilising services across all care groups, CAMHS and Psychological Therapies performance/waiting times, pressure on in-patient units, and high levels of staff absence/ vacancies across all services. The work to date with Psychological Services is referred to above.

12.14.2. As above the CAMHS service review is underway and we now have a programme of work and a number of improvement actions to take forward over the next 12 months. Particular areas of focus are: rapid engagement, the development of a stakeholder reference group, how to more effectively design the pathways for mood disorder (MD) and neurodevelopment (MD).

12.14.3. There is also on-going monitoring and planning the projections of the waiting list through the coming year 2021/2022.

12.14.4. With regards to the Mental Health services projects and actions to be taken forward during 2021/22, work is underway with the Mental Health Division and NHS Borders to determine the specific outcomes of these and the timescales. A dedicated project manager for mental health has recently commenced post and is supporting services to do this. Our action plans with clear timescales will be available by the next iteration of this Remobilisation Plan.

12.15. **Mental Health Services – Waiting Lists Backlog Management**

12.15.1. Mental Health services are working with the Scottish Government Mental Health Performance, Remobilisation and Renewal division since being selected as one of the Boards to receive a tailored programme of enhanced improvement support, as described above. One of the key focuses of this work is on CAMHS and Psychological Therapies performance/waiting times and high levels of staff absences and vacancies across all services.

12.15.2. As described above within the CAMHS section, a temporary Nurse Led Opt in Assessment appointment system has commenced in January 2021 to ensure that patients on the CAMHS RTT waiting list are offered an appointment. This section also refers to the success of recruitment to nursing and psychology posts within CAMHS which should see a positive impact on the waiting times.

12.15.3. As described above within the psychology service section, CAMHS has had a challenging time in 2020 due to staff sickness and vacancies. However, work with the Mental Health Division in the Scottish Government and NHS Borders initiatives are starting to yield a positive impact, and we expect to be fully staffed in 2021. Initial recommendations include developing a short, medium and longer term plan for psychological therapies that include waiting list management planning to deal with longest waits.

12.15.4. To tackle the backlog of waiting times as at 31 September 2021 we will continue to work with the Scottish Government including scoping the resource to ensure a critical floor in terms of staffing.

Priority Areas for Collaboration and Mutual Aid

13. Collaboration has been critical at every stage of the pandemic response so far and will remain central to our approach through 2020/21. Partnership working with Scottish Borders council will continue to ensure patients are discharged to the right care in a timely fashion. The reinvigorated Health & Social Care Partnership Group will continue to focus on joint work to streamline pathways and collectively respond to any further COVID-19 peaks. Acute Services are building on their relationships with the third sector to explore where value can be added in this new pandemic world.

13.2. The waiting times plan assumes use of the Golden Jubilee Hospital for Orthopaedic cases should this be funded by Scottish Government. NHS Borders are open to the use of other external providers if revenue and workforce solutions can be found to do so. SAS have proven a critical partner through the pandemic. Provision of a Hospital Ambulance Liaison Officer (HALO) role through the winter months has helped more patients home sooner. This partnership will continue.

13.3. The waiting times backlog that has accrued over the previous year will not be recovered quickly, and requires different thinking. NHS Borders are keen to work with regional partners to explore how we collectively ensure an equitable service for patients across the region as we seek to safely manage the backlog.

13.1 **Regional Working**

13.1.1. As the constituent core Boards in the East Region Planning Group, NHS Borders, Fife and Lothian enjoy a long standing and mature relationship in collaborative working. The Chief Executives have confirmed their commitment to ensuring that the populations served by their respective Health Boards continue to receive the best possible healthcare in as equitable a manner as possible, with pre-existing arrangements whereby partner Boards offer assistance and support should there be an untoward or isolated service delivery issue. Each Board has in place an agreed local framework and process to support identification, assessment and escalation of service pressure and delivery risk, with corresponding Board level actions and mitigations. Where there is major system demand which cannot be managed within Boards, Boards can request mutual aid from partner Boards which will be considered in the spirit of delivering the commitment above.

Enablers & Inter-dependencies (Inc Innovation)

14. **Digital Innovation**

14.1 Having focused and redirected all IM&T staff to COVID-19 response we are now working to consolidate the significant steps made in implementing digital technologies. A period of stabilisation is required to bed in some of the new ways of working and ensure adequate support, security & governance for the technology that's been deployed. In addition we are reviewing our plans and capacity alongside service needs to support remobilisation while trying to manage risks that were already inherent within the infrastructure. Some key areas of work in flight and planned are as follows:

14.1.1 <u>Network Connectivity</u>

14.1.2. Increased home working and additional cloud based solutions to support COVID-19 has highlighted further the reliance on adequate connectivity and sufficient bandwidth to access services. Investment has been made to partially deal with the most immediate need but further work is necessary across some locations and potentially non NHS locations to allow staff to access services and systems they need. A significant Firewall upgrade was completed on our external internet connection to increase throughput. However that link is now under pressure and further work is required. Performance at some of our sites is particularly poor and will require additional investment.

14.1.3. Discussions continue with Capita & NSS around potential SWAN upgrades to community links to GP's and Community Hospitals. We are also looking at a redesign of the NHSB network to try to increase band-with capabilities by leasing additional lines. This would future proof the organization for the introduction of Full O365 & GP-IT. We continue to work on the design of the architecture to deliver the best outcomes but it may not be possible to deliver all the connectivity desired within current resource e.g. Public Wi-Fi in GP Practices or connectivity to locations without Wi-Fi.

14.2 Remote working

14.2.1. Due to the way Technology is delivered within NHSB the IT teams are able to provide & support the majority of systems and application remotely, although telephony is becoming an issue for Service desk teams working from home. We continue to provide high levels of Service while allowing flexibility on ways of working both during the response and now into the recovery phase.

14.2.2. We have supported over 1089 staff to work from home, providing over 700 devices. We continue to monitor and report on remote traffic and performance allowing us to understand capacity and giving the organisation the ability change the on-site/off-site model as and when.

14.3 NHS Near Me

14.3.1. All high priority services have now been enabled with Near Me and suitable technology. Uptake has been good but remains fairly static. There is more to do to facilitate Outpatient activity across all suitable services and to extend its use as services come back on line. The lack of group consultation solutions is hampering Mental Health in particular. We will move forward to expand its use and reach a sustainable position within services so that eHealth staff can focus on other work. A significant challenge is in securing accommodation for clinicians to undertake Near Me consultation while maintaining social distancing across services.

14.4 MS Teams

14.4.1. MS Teams accounts have been created for all staff with around 53% active use. We have some performance issues at some of our sites which has prohibited the implementation of the full desktop client to all users. MS teams has been invaluable and enabled most teams to work effectively. A period of consolidation and stabilisation is needed.

14.5 O365 / Mail

14.5.1. We completed the national mail migration from NHS mail and are planning for migration of the local mail solution during 2021. This will be a significant step towards securing collaboration benefits and solving some challenges presented by the current mixed mail environments. There remain a number of application dependencies with legacy systems which we are trying to address prior to migration. We are short of technical skills in this area and have used contract resource intended for other work to implement and support.

14.6 Windows 10

14.6.1. Much of our desktop estate remains on Windows 7 operating system and must be migrated. This will improve our security position but is also needed for applications including O365 to run effectively. Included within this is a significant desktop device refresh. We are considering contracting a third party to deliver that part of the programme. Staff skills and capacity continue to hamper our preparation work.

14.7 Trak Upgrade

14.7.1. A major upgrade from T2010 to T2018 for Trakcare was completed in July 2020. This mitigated a key a major risk area for NHS Borders. We are now working on plans t leverage more new functionality and deliver additional improvements to support services in their recovery by streamlining some tasks and reducing the reliance on paper notes.

14.8 Remote Monitoring

14.8.1. We are aware of the national product and continue to participate. Our local authority also has a product offered by their IT partner which is being considered. So far clinical services have not considered how remote monitoring could feature within their recovery plans so we will wait to learn from others. It is possible the local authority may decide they have a pressing need to support people shielding which may drive the tactical direction.

14.9 COVID-19 related services

14.9.1. NHS Borders contact tracing service, testing teams and vaccination service continue to be a priority for Digital support as the situation and requirements evolve through the pandemic. Teams are working within local buildings currently though this may change.

14.10 Business Intelligence

14.10.1. A local dash boarding / BI tool has been part of our strategy for some time and we had been working with NSS to implement Tableau. This work has resumed alongside COVID-19 related activity. Some god progress has been made and we hope to accelerate that during 2021 to help better support with planning and monitoring for remobilisation and on-going COVID-19 response. There have been many challenges in collecting, accessing and compiling data for COVID-19 reporting which have put pressure on a very small team. Access to some national reports is very welcome but supporting the information needs of the organisation is still very resource intensive. It seems likely we will need to create some additional capacity to move to a more automated way of working.

14.11 Forward Planning & Risk

14.11.1. We have some 120 projects / work packages from across the organisation in our Digital pipeline with more appearing every week as teams consider how to bring back services in a different way. Many of these relate to risks already known to us internally, improvements services want to make or outside influences. Some can come with dates which are imposed on us and if not met present additional risk to our services e.g. supplier pressures / ending support adding additional pressure to an already stretched team. We cannot deliver everything that is likely to be required of us within the resources and skill mix we have. We are currently reviewing and prioritising all work to see what is essential and affordable and fits with the remobilisation of services and best manages risks.

14.12. **Development of New Models of Care - Renew/Redesign**

14.12.1 Discharge Referral Management

14.12.2. STRATA automates and improves the process of discharging patients from hospital to residential care or care at home providers. The system uses a real-time directory of available care home beds, capacity and specialist services allowing these to be matched to patients. The digital system is supported by creation of an integrated discharge 'hub' as a single point of contact multi-disciplinary team with responsibility for coordinating and arranging older people patient transfers and ongoing care.

14.12.3. Strata is now managing around 800 referrals / month in eight pathways across hospital, social care and third sector. It takes a median time of 10 minutes for staff to submit a referral.

14.12.4. The re-launch of the domiciliary care referral pathway is imminent and will be followed by the pathway for referral to Community Hospitals in the next quarter. These are key in enabling BGH and community hospitals staff to directly refer for intermediate care and will be a step towards enabling community teams and GPs to access these through a simple single 'red button' referral process for step up from the community.

14.12.5. We are also considering whether STRATA can be used as a tool to support referrals into the developing Community Treatment and Care Services which we hope will provide treatment and care both from a Primary Care Improvement Plan perspective, but also will support patients in secondary care to have local, coordinated access to tests and investigations across our remote and rural area.

14.13. Mental Health Transformation Programme

14.13.1. The Mental Health Team is aiming to restart the Mental Health Transformation Programme over the next 12 months as we remobilise our services. This will be focussing on a number of areas including the Community Mental Health Teams, the Crisis Team, and other commissioned services.

14.14. **Patient Transport**

14.14.1. The NHS Borders Patient Transport Service was established on 30th March 2020, initially to provide transport for people with suspected COVID-19 attending the COVID-19 Assessment Centre at the BGH. A further need for transport for patients being discharged from hospital or Emergency Department with known or suspected Covid was rapidly identified. The service was extended further as additional needs arose:

- Need for rapid discharging of non-COVID-19 patients to maintain patient flow through the hospital with reduced non-COVID-19 beds
- Introduction of shielding meant that many users of outpatient services were unable to access public or private transport
- Supplementing Scottish Ambulance Service capacity due to restriction to a single passenger per vehicle

14.14.2. The service currently provides transport for patients attending the COVID-19 assessment Centre, people attending the Drive-through testing hub who do not have their own transport and for discharges from wards and Emergency Department of known or suspected COVID-19 cases. The service is also providing a discharge vehicle between 2pm and 9pm to facilitate general discharges and supp.

14.14.3. The service currently also provides transport for vulnerable patients attending outpatient services and unable to transport themselves (where they do not meet Ambulance Service criteria) and the service is currently replacing the volunteer dialysis transport service, where volunteers are themselves currently shielding. The service has picked up a new service delivering oral Cytotoxic medications to patients' homes, thus avoiding patients having to travel to the BGH to receive these.

14.14.4. More recently, the service supports transportation of staff and patients for flu vaccination and COVID-19 vaccination.

14.14.5. The service comprises the following resource:

- 7wte drivers
- 4 vehicles
- Transport booking hub (1wte administrator)

14.14.6. The driver team is integrated into the General Services Team to maximise flexibility of resource. The service relies on access to 4 vehicles – 3 minibuses currently on long-term hire from Arnold Clark, and one BECS vehicle, as well as general fleet vans for non-patient transport.

14.14.7. The service operates 7-days per week, between 0700 and 2100, with some provision through General Services for ad-hoc journeys outwith this time, thus representing a 24-hour service.

14.15. Activity

14.15.1. The service has undertaken in excess of 3,736 journeys during this 40 week period, averaging 100 journeys per week overall, although activity has increased in later weeks and is averaging closer to 140 journeys/week. There are some data gaps, meaning that activity is likely to have been higher than this.

14.16. Future plans

14.16.1. The service has been extended until October 2021. A review of future transport needs is currently being undertaken to determine whether a local patient transport service should be maintained on an ongoing basis and what model of transport provision would be most effective. An option appraisal is planned to determine a final business case. It is hoped that the future transport strategy will have been agreed by April or May 2021.

14.17. **NHS Borders Estate**

14.17.1. NHS Borders is constrained in its ability to adapt due to an aging estate and the mitigations in place to support this such as a backlog maintenance program, there are also limited resources both financially and physically to support. However there are several planned activities in 2021/22 to support remobilisation:

- Dedicated project management resource both for building and engineering
- Space utilisation/ management survey
- Functional Sustainability Assessment
- Primary Care Strategy development/ update
- Property Strategy update
- Signage Strategy
- Provision of additional storage space
- Continued partnership working with Scottish Borders Council

14.17.2. The Estates and Facilities Team are also planning to undertake a full service review within 2021/22.

14.18. **Clinical and Professional Development (C&PD)**

14.18.1. All scheduled classroom clinical skills, resuscitation and practice education training remain discontinued to align with new ways of working in support of the pandemic response. A variety of online skills methods have been combined with Observed Structured Clinical Examinations (OSCEs) where appropriate.

14.18.2. Increased infection control measures including additional alcohol gel are provided in classroom settings and appropriate masks, gowns, gloves personal protective equipment (PPE) is mandatory for Facilitators & Participants during Clinical Skills Training. Staggering start / finish times and controlling flow of participants entering or leaving classroom settings remain in place.

14.18.3. COVID-19 Immunisation Education materials are hosted via the organisations LearnPro Competency Assessment and Recording Tool. This provides an excellent governance resource for staff to evidence competence, compliance and skills. It hosts eLearning, presentations, videos, policies and OSCE assessment frameworks in one place and links to personal scorecards.

14.18.4. C&PD continues to interpret and provide educational solutions to changing contemporary evidence based care; professional body and governance requirements; service redesign and employability priorities, and is now testing and implementing new ways of working to deliver educational priorities:

- Redesign of Urgent Care
- Key role of Primary & Community-based Care
- A whole system approach to Mental Health & Wellbeing
- Planned care & Clinical Prioritisation
- Patient Experience

14.18.5. Access to socially distanced PCs and a quiet space to study while limited is in place, to support disadvantaged staff groups with unreliable access to technology, competition with others members of their household for technology and underdeveloped skills for independent on-line learning.

14.18.6. NHS Borders is receiving increasing demands from GP practices and external organisations working in partnership with NHS Borders for free access to NHS Borders eLearning materials. Funding for neither this service nor the additional capacity required for the eLearning helpdesk is available. Conversion of existing NHSB eLearning into content that can be hosted on websites rather than a specialist learning management system are currently being prioritised. However, this option does not provide any educational governance function.

14.18.7. Service redesign plans will assure new ways of working reflect a new sustainable delivery model.

14.19. **Medical Education**

14.19.1. The medical students returned to NHS Borders in August 2020. Prior to their return accommodation needed to be upgraded to allow for social distancing and bubbles of three. Students were asked to limit travel between tiers to reduce risk of spread prior to lockdown. Guidance was set up for the management in the event of an outbreak in discussion with our partner Boards in South East Scotland. This was enacted guidance refined accordingly.

14.19.2. Teaching and training recommenced for medical students and foundation doctors in August with appropriate social distancing and facilities for digital access. However, space is more limited than pre-COVID-19 due to teaching accommodation being used for COVID-19 activities. Availability of Wi-Fi across the estate is variable, limiting online access to teaching / training. Medical Education has raised this with IM&T who are conducting an organisational review of Wi-Fi provision. In the meantime, Medical Education is investigating the provision of mobile Wi-Fi in the student residences.

14.19.3. Initially medical students were restricted clinically to non-COVID-19 areas and rotations adjusted resulting in reduced clinical exposure time on wards at the request of the University. After the first rotation of students this was changed with agreement from the University to enhance exposure to inpatient activity but without outpatient activity due to limited space.

14.19.4. Similarly, for trainees, in remobilisation of outpatient services, they were not factored in for clinic access or Near Me consultation space. Towards the end of the year Near Me space had been provided but was removed from Consultants due to lack of clinical outpatient rooms. Currently Medical Education is liaising with services and the outpatient remobilisation group for future accommodation of trainees.

14.19.5. Simulated training was suspended and has been difficult to reinstate due to space availability but educators are looking at the possibilities. ALS has been reinstated and we

had our first successful course on 25 November 2020 with a further course planned for April, with appropriate social distancing.

14.19.6. Physicians Associates students commenced their first rotation in NHS Borders on 5 January 2021 and will be with us until July. Some are interested in working in NHS Borders and may contribute to a more sustainable workforce in future.

14.19.7. As protocols changed frequently during COVID-19, an app was developed to make them available on smart devices, making it easier to find and use them in the workplace. Medical Education is working with Clinical governance and Quality and the Scottish Government Right Decision Service to trial a new app to provide clinical guidelines, protocols and policies via a Smartphone app and website to provide a longer term solution to the problem of access.

14.19.8. Redeployment has been kept to a minimum and in line with agreed guidelines from NES.

14.19.9. Medical Education is currently commencing planning for induction in August 2021 in a socially distanced environment.

Engaging With Our Stakeholders

15. Our overriding organisational objective of providing high quality, person centred services that are safe, effective, sustainable and affordable remains. In doing so it is a vital component to actively seek and use the views of patients, their families, carers, the community and our staff to design and deliver services that best meet their needs; and communicate the actions we take as a result of the feedback received. The commitment to engage extends across our Integration Joint Board (IJB), working with Scottish Borders Council (SBC), the third sector and other partners to deliver the best possible health and social care for the people of the Borders.

15.2. As we emerge from the second wave of the COVID-19 pandemic we will continue to work alongside the Community Engagement team in Healthcare Improvement Scotland to consider how we effectively engage with the public and our partners within the boundaries imposed by the preventative measures we are all living with now. We will continue to listen and to do everything we can to 'respond, recover and renew' effectively and efficiently, keeping our patients and each other safe.

15.3. Through the supportive framework of NHS Borders' Recovery Group the Communications and Engagement (C&E) team will continue to work alongside business units in order to advise and support on specific C&E requirements in relation to the resumption of services.

15.4. The narrative for the public and partners will undoubtedly build on the key messages established when we emerged from the first phase of the pandemic which outlined:

- Resumption of services will be done incrementally to ensure patient and staff safety is prioritised whilst retaining capacity to treat COVID-19 in our health service.
- As services resume, the experience of patients accessing services will continue to look and feel different.

- Service delivery will continue to take longer because of the demands of ensuring this safety, such as the need to reduce numbers in waiting rooms, additional cleaning and the use of PPE.
- The ongoing development of our remobilisation plans is founded on a whole health and care system approach, which involves primary and community care, and engagement with clinical partners, service delivery partners, local authorities and patients.

15.5. We will continue to engage via our public involvement networks and are looking to expand these networks in order to understand the impact of the changes brought about by COVID-19 and how we build the feedback we receive into our remobilisation plans.

15.6. In addition to learning from the patient experience and as referenced earlier we are also undertaking a significant piece of staff engagement work entitled 'Collecting Your Voices' in which staff have been sharing their experiences of responding to the challenges and opportunities of working during the COVID-19 pandemic. As mentioned previously, phase one of this work is now complete and the insights gained are already being fed into our planning cycle. A second phase of work targeted at staff working in community settings is now underway.

Supporting Our Workforce

16. **Sickness Absence**

16.1. In the period February to end of April 2020, NHS Borders saw its level of absence increase substantially. The average level of sickness and COVID-19 related absence in that time was a lot higher than in the equivalent period in 2019. In April 2020 the level of absence away from the workplace doubled. During the height of the pandemic, a central absence line was operated for acute staff ensuring that employees could inform the organisation at the first opportunity that they were unable to fulfil their shifts/work obligations. At this point, measures were enacted to cover for those absent colleagues e.g. bank staff brought in or existing staff working extra hours. That central absence line was stood down but there are plans to re-instate it across the whole Health Board in the event of future COVID-19 waves/spikes. Between July and December the rate of sickness absence fluctuated between 4.75% and 5.5% with the rate of COVID-19 related absence decreasing. With the exception of one month the rate of sickness absence has been lower in 2020 compared to 2019. In addition to monthly reports, weekly absence reporting was introduced to inform and aid decision making within business units.

16.2. Since the launch of the new Workforce Attendance policy absence management focus groups have been established to support line managers actively encourage and support employee attendance. During 2021 our Managing Attendance eLearning module and classroom training for managers will be reviewed and updated and will include Promoting Mental Health and Wellbeing training.

16.3. NHS Borders established a Staff Wellbeing Group in March 2020 in response to COVID-19. The group is a collective of managers, staff side members and representatives of service areas including Communications, Fundraising, Psychology, Public Health, HR and Occupational Health. The group was instrumental in the establishment of Here4U; a

telephone counselling service run for the workforce. A microsite was established for staff to sign post resources available to support physical, emotional, psychological and financial wellbeing. The work of the group will continue to promote and support the wellbeing of staff. The group also engaged with the Collecting Your Voices project which has sought to achieve maximum learning from individual's perception of NHS Borders' response to COVID-19, the learning continues to inform our ongoing responses.

16.4. In September 2020, NHS Borders participated in the Everyone Matters Pulse Survey. This survey asked 13 staff experience and wellbeing questions. An action plan will be developed from this to support improving employee experience. The staff experience continuous improvement tool, iMatter, will be run in 2021 to help individuals; teams and the Health Board understand and improve staff experience.

16.1. **Staff Health and Wellbeing**

16.1.1 COVID-19 has had a profound effect on the health & wellbeing of many parts of the workforce and in a variety of ways. Some staff have contracted COVID-19 and been absent from the workplace with debilitating symptoms, some staff have been required to isolate, some have shielded, some staff may still be feeling the effects of Long-COVID and NHS Borders sadly had one fatality in the workforce, attributable to COVID-19. For those staff who have remained at work throughout waves one and two of the pandemic, many have worked with very high levels of patient acuity, worked under intense pressure for a sustained period often away from their usual workspace/colleagues and many have filled in gaps and performed additional hours when colleagues have not been available to work.

16.1.2. In February/March 2020, NHS Borders established a Staff Wellbeing Group, co-chaired by the Employee Director and Director of Workforce. That group was instrumental in setting up the Here4U service which has supplied telephone/Near Me counselling and psychological support to staff who have felt anxious, stressed or depressed. The group has organised food and drinks parcels for busy ward-based staff, negotiated free hot beverages in the staff dining room, lobbied for regular breaks and in response to concerns about hydration for staff working in full PPE, used Charities Together funds to purchase water bottles for staff. The group also supported a staff engagement program called *Collecting Your Voices* which sought staff opinions on the handling of the pandemic before the national Everyone Matter Pulse Survey was launched. The response was strong; high in numbers and rich in content.

16.1.3. There is real concern that after such a sustained period of intense, physically & emotionally draining work, some staff may be *running on empty* and badly in need of rest & recuperation to get over the travails of the last 12 months. Some professional journals are reporting the risk of post traumatic stress disorder for those staff who have worked on COVID-19 and intensive care wards. Many staff will need time to decompress, reflect and recharge their batteries before a return to all of the pressures that already existed pre-COVID-19.

16.2 **Deployment of Staff to Meet Service Demands/New Models of Care**

16.2.1. Early in the pandemic a Deployment Hub was established, tasked with getting staff to the areas most in need of resources. This saw staff groups such as Community Dental/Oral Health staff and Theatre staff redeployed into Test & Protect/Contact Tracing services. Mental Health Nurses and Community Nurses moved to COVID-19 wards. Shielding staff joined phone lines for the seasonal flu and COVID-19 vaccination contact centre. One of the lessons from the aforementioned *Collecting Your Voices* initiative asked that individual preference be given as much credence as organisational need and this was embraced.

16.3 **Anticipatory Workforce Planning & Recruitment**

16.3.1. NHS Borders Recruitment Service has never been as busy as it has in the last 12 months, having seen recruitment activity grow to 3-4 times pre-COVID-19 levels. Brand new services have been established like the COVID-19 Assessment Hub, Test & Protect/Contact Tracing, outreach into Care Homes and the establishment of a Vaccination Contact Centre. Existing services like Infection Control have been enhanced. Liaison with new initiatives like the National Portal was necessary to secure extra resource for the pandemic response. Throughout all of this, usual winter pressures have prevailed and staff have continued to turnover in terms of retirements and job changers. We are watching closely to see if a combination of the 2015 changes to NHS Scotland's pension scheme, the McCloud court case and a gruelling last 12 months will see an increase in the rate of staff retirements.

16.3.2. NHS Borders is preparing its 2021-2022 Interim Workforce Plan by the end of April 2021 and this will form a component part of a wider Workforce Strategy 2021-2024 which will also incorporate Resourcing, Learning & Education, Organisational Development, Health & Safety and Equality & Diversity elements. The strategy will be devised to complement national imperatives and local clinical, estates and equipment strategies. With an ageing workforce and one with only 3% identifying as Black Asian or Minority Ethnic, it is vital that NHS Borders can sell itself as an exemplary and progressive employer which is a great place for health & care staff to learn and further their careers.

16.4 **Roles of Area Partnership Forums and Employee Director**

16.4.1. The Area Partnership Forum (APF) will continue to meet in order to support agile decision making in our organisation. It will be cited on all elements of the COVID-19 response as well as being central to key workforce and policy decisions and developments and changes. We continue to see a regular and high attendance at these meetings on MS Teams and will continue on this platform indefinitely.

16.4.2. The APF has in recent meetings been progressing towards more business as usual (BAU) aspects including staff governance issues, monitoring and support decisions around TURAS, IMatter and Sickness Absence. It is supported by the work of the Policy and Conditions of Employment (PACE) Group, the Equalities Group, The Staff Well Being Group and the

Occupational Health & Safety Committee of which many of the APF members, both management and trade union members sit on these.

16.4.3. As Employee Director it is essential to lead on Staff Wellbeing as we are challenged by the complexities of BAU services required for our most vulnerable along with demands of winter pressures and needs for COVID-19 provision of care which is why the ED jointly chairs the Staff Wellbeing Group with the Director of Workforce. The terms of reference for the staff wellbeing group have been embedded into our organisational structure with escalation processes to OHSS Forum and through APF. The group is responsible for support a range of work strategies through Work and Wellbeing and Public Health/Health Promotion, healthy working life initiatives and advocating and supporting use of endowments for staff support. This includes practical support through hydration project, access to hot drinks, food and refreshments including fruit on an ongoing basis. This will be reviewed before end of March 2021. Also provision of online exercise is provided through online yoga. We continue also to support the work of the Psychological Wellbeing Hub and Here4u initiative now part of business as usual through Occupational Health.

16.4.4. It is a key responsibility that Employee Director works alongside the trade unions to maintain assurances for the safety of our staff and this is done through working with a team of Partnership leads from 4 Business Units in key management meetings and discussions. This includes at Board Level, Board Executive Team, Senior Management meetings such as Gold Command and PPE Committee.

16.4.5. We have together ensured that the Local Partnership Forums are running alongside APF to support local discussions and decision-making. These will continue to report and escalate if required issues to the APF.

Remobilisation- Assessment of Risks & Mitigations

17. **COVID-19 Risk Register**

17.1 As part of the organisation's response to COVID-19 a risk register was developed. This is now embedded into the organisation and is reviewed on a regular basis at Gold Command. Risk appetite is monitored throughout and any risks outwith the organisation's risk appetite are fed into Gold Command for action and decision.

17.2. Deep dives into the COVID-19 risk register are also undertaken on a two monthly basis by the Risk Management Board. Non COVID-19 risks are monitored through the Risk Management Board and a timetable implemented to monitor the most significant risks. Any risks outwith risk appetite are fed into the Risk Management Board for decision and onwards to the Clinical Executive Chair and Board Executive Team for agreement.

17.3. All adverse events continue to be recorded, closely monitored and investigated. These are fed into the organisation via adverse event reports to operational and governance groups. Reporting of adverse events at a national level is continuing.

17.1. **Impact of EU Exit**

17.1.1. The United Kingdom exited the European Union on 31st January 2020, and the transition period applied until 31st December 2020. NHS preparations for a "No Deal" scenario were reinstated in autumn 2020 following a temporary suspension of planning due to the Pandemic. In the event the United Kingdom and the European Union agreed a trade and cooperation agreement shortly before the end of the transition period. The agreement led to no tariffs or quotas on the movement of goods produced between the UK and the EU.

17.1.2. A multi-disciplinary EU withdrawal sub group had been established within NHS Borders and there is a joint planning group with Scottish Borders Council. These groups have continued to meet after the end of transition period to review any impact of EU withdrawal, which thus far has been negligible. In the immediate period after the end of transition, a resilience / emergency planning approach to concurrent risks was adopted to maintain essential services but the long term impact of E.U. withdrawal must influence our planning.

17.1.3. The overall Brexit uncertainties and outcomes that have been identified on the NHS Borders strategic risk register. On the conclusion of trade and cooperation agreement the risk rating on the strategic risk register was downgraded to "medium". The following is a summary of the risks and mitigations

- **Workforce:** identified labour market risk that retention and recruitment of health professionals may decrease / negative perceptions of EU nationals of working in UK. The focus has been on identifying and supporting EU nationals already in our workforce, maintaining regular contact and highlighting the settlement scheme and deadlines.

- **Procurement:** risk to supply chains and restricted access to EU suppliers, loss of negotiated reduced contract rates / tariffs. Potential impact on access to technology. There has been close working with National Procurement, an escalation process was established but significant disruption to procurement and supply chains has not yet been identified.

- **Pharmacy:** loss/disruption of access to supplies of pharmaceutical supplies/medicines/medical consumables from European Union. Manufacturers and suppliers have contingency plans for security of supply and the National Distribution Centre initiated a stock build on high volume items being stocked to levels based on COVID-19 experience. No significant disruption has yet been identified.

- **Catering / Food Security:** supply disruption, restricted menu planning / healthy options / nutritional requirements due to availability of fresh produce as well as potential cost increases. The catering department has not been affected in its day to day operation by Brexit.

- **Financial:** long term economic outlook, international currently fluctuation. Potential impact on funding allocation to Health Boards and increasing costs for EU supplies. NHS Borders has not yet identified a financial impact of Brexit.

- **Public Health:** collaborative and aligned approaches/research is restricted, cross EU health initiatives decline. Early warning of communicable diseases declines; long term economic outlook and poverty related ill health. With prioritisation of the public health response to the COVID-19 pandemic, there has been no assessment as yet of the impact of Brexit, although this will continue to be monitored.

- **Cross border care:** EU nationals seeking healthcare whilst in UK. Mechanisms for financial recompense / payment uncertain. Locally the regulations have been implemented.

Finance

18. **Introduction**

18.1 The board will submit its draft financial plan alongside this plan for 2021/22. In line with the changes to the AOP process, this financial plan will be a one year revenue expenditure plan, accompanied by an update to the board's five year capital plan. Both the revenue and capital plans are prepared as an update to plans submitted in March 2020 as part of the 2020/21 Annual Operational Plan.

18.2 A summary of the issues outlined within the plan is provided below.

18.1 **Financial Plan 2021/22**

18.1.1 **Summary**

18.1.2 The draft revenue forecast for the board's performance projects a £5.4m deficit at end March 2022. This projected deficit remains in line with the in year performance identified in our three year plan prepared in March 2020.

18.1.3. This position assumes that costs associated with this plan will be fully funded, and is predicated on actions available to manage performance as described in further detail below. A significant factor influencing forecast expenditure will be the extent to which the COVID-19 vaccination programme is delivered in line with anticipated phasing plans, and consequent impact on timing for remobilisation of services.

18.1.4. It should be recognised however that the plan also highlights an increase to the board's recurring deficit of c.£6m against previous forecast, with actions to manage this in 2021/22 reliant on a number of non-recurrent measures. Financial sustainability for 2022/23 and beyond is therefore expected to present an increasing challenge and we intend to progress with the development of a three year financial plan in the early part of 2021/22 in order to evaluate the impact on forward planning for the post-pandemic period.

18.2 **Background**

18.2.1. The board's financial plan for 2020/21 was prepared prior to the onset of the COVID-19 global pandemic. This plan presented a three year revenue forecast which described

assumptions around available resources and expenditure commitments over the term of that plan, together with actions available to manage the financial gap identified in the plan. This included a request for ongoing financial flexibility (i.e. brokerage) over the three years to March 2023. The following table summarises the projected recurrent and in year financial performance outlined in this plan.

18.2.2. Summary of AOP 2020/21 to 2022/23

	2020/21			2021/22			2022/23		
	R £m	NR £m	Total £m	R £m	NR £m	Total £m	R £m	NR £m	Total £m
In Year Deficit	(16.5)	(1.6)	(18.1)	(14.4)	(0.6)	(15.0)	(11.7)	(0.3)	(12.1)
Estimated Savings	3.2	7.1	10.2	5.0	4.7	9.7	5.0	4.4	9.4
Outturn Forecast (net)	(13.4)	5.5	(7.9)	(9.4)	4.0	(5.4)	(6.7)	4.0	(2.7)

18.2.3. The 2020/21 plan projected a reduction to the board's recurring deficit at end March of £13.4m. Following the onset of the pandemic, the board suspended its financial turnaround programme with project management resource redirected to support the recovery and remobilisation response. As at February 2021, this position remains extant. The impact on recurring savings delivery in 2020/21 has been a reduction to planned savings of £1.6m.

18.2.4. The introduction of the LMP mechanism for in year reporting and forecasting of COVID-19 expenditure has resulted in significant changes to the projected financial performance in 2020/21. The LMP for 2020/21 projected additional costs of £27m across both health and social care within the Scottish Borders, including support to slippage on delivery of savings plans. This support, together with a reduction in operational expenditure resulting from the demobilisation of core services, has removed the need for brokerage support in 2020/21 and the board is now projected a breakeven performance at March 2021.

18.3. **Key Assumptions**

18.3.1. The plan is developed in line with national planning assumptions. The following section highlights a number of specific assumptions which underpin the draft plan:

Issue	Assumption
Pay Uplift	Pay uplift is modelled in line with the public sector pay policy published on 28th January. It is assumed that any additional costs arising from NHS pay settlement will be resourced by additional allocation.
Deferred Annual Leave	The increase to deferred annual leave as at March 2021 will be accrued in the board's annual accounts. The impact of COVID-19 on staff leave is expected to be financed by additional allocation in 2020/21.
Waiting Times	Waiting times funding for Acute performance (outpatients, diagnostics, inpatient/day case treatment, cancer) is assumed at the same level as previous years. As agreed with the Scottish government access support team an element of this funding (£1.1m) is committed recurrently through increase to core service capacity.
Winter Plan	The board's winter plan for 2020/21 included additional expenditure of £1.5m. Funding available through SG allocations is assumed at previous levels (£0.2m). The financial plan assumes that both expenditure and funding will be in line with previous levels however it is intended to review plans during 2021/22 with the aim of identifying actions to reduce this pressure.
Drugs Policy	The plan excludes any consideration of the national investment of £50m (Scotland) in drugs policy. It is assumed that plans for this investment will match available resources.
Reshaping Urgent Care	Expenditure on RUC is included within the RMP3 modelling. This includes phase I investment implemented in 2020/21 and expected to be recurrent, as well as a step increase based on current modelling to be implemented on a part year basis in 2021/22.
Nursing leadership in care homes	It is assumed that current arrangements will be in place for the full period to end March 2022.
Test & Protect	The workforce model implemented within NHS Borders highlights a financial gap against the ring-fenced resources made available to support contact tracing. It is assumed that this shortfall will be resourced through this plan.

18.4. **Expenditure Commitments**

18.4.1. The plan is prepared on the basis of the board's projected resources and expenditure commitments for the 12 months to end March 2022. This includes update to the underlying (recurring) deficit, together with additional costs arising from pay and price growth and unavoidable commitments arising from national, regional and local developments and cost pressures. Against this the board has reflected the level of uplift outlined in the Scottish Government draft budget published on 28th January 2021.

18.4.2. The board's plan describes an opening recurring deficit of £14.3m, an increase of £0.9m from the level projected in the 2020/21 financial plan. This is a direct result of the slippage on delivery of savings programmes and it is anticipated that this recurring deficit will continue to grow during 2021/22 with the development and implementation of savings plans a significant risk to the plan at this stage.

18.4.3. Aside from RMP3, the plan describes additional expenditure growth in excess of the level of uplift available to the board. Key drivers for this expenditure growth are hospital and primary care prescribing, estimated impact of safe staffing legislation, increase to top-slice for national risk share arrangements, and regional and local cost pressures, including the additional costs associated with the opening of the Royal Hospital for Children and Young People in Edinburgh.

18.4.4. Costs which are driven by service demand (e.g. prescribing) are likely to fluctuate according to the scale and phasing of service remobilisation and this is an area where close monitoring arrangements will be in place through the existing quarterly review process.

18.4.5. Excluding this plan the board projects an in year gap of c.£20m before identification of savings and other actions available to manage financial performance in 2021/22.

18.5 **Remobilisation expenditure**

18.5.1 Expenditure in relation to Remobilisation includes forecast costs for both health and social care relating to the Scottish Borders Health & Social Care partnership. Financial forecasts remain subject to further review. The RMP3 financial model includes estimated costs for the following areas:

- Public health & Infection control measures – including local and community testing, contact tracing, care home supervision (including leadership changes), enhanced cleaning regimes, waste management, etc.
- COVID-19 response management – including the impact of social distancing measures on hospital and community staffing levels, additional resources required to maintain green (elective) pathway, additional bed capacity to meet projected demand for COVID-19 admissions, and the continuation of new service models (e.g. community hub).
- Remobilisation plans – the forecast is prepared in line with the projected phasing of remobilisation of services.
- Vaccination programme – the board's COVID-19 vaccination plan remains in development. Costs are included in line with the most recently submitted vaccination

cost template. The plan also includes an estimate of additional costs for seasonal flu based on an enhanced programme in line with winter 2020/21.

18.5.2. The Remobilisation expenditure forecast is developed on the basis of national planning assumptions, including the anticipated remobilisation of services by midyear (September). A number of commitments are expected to continue beyond this period, notably actions required to maintain public health and infection control measures, as well as a (reduced) level of ongoing capacity for COVID-19 response. This is described in further detail in the financial plan template.

18.6. **Efficiency Savings**

18.6.1. As described above, the board's financial turnaround programme was suspended in March 2020 at onset of the pandemic. A phased reintroduction of activities to support efficiency savings is planned for the period up to June 2021; however this remains contingent upon release of project management support and management capacity to support.

18.6.2. The financial plan assumes that delivery of recurring savings will be at 50% (£2.5m) of the original level described in our pre-COVID-19 plans and does not include any recovery of the shortfall on delivery in 2020/21. At this stage development of detailed plans has not yet been undertaken and this remains a significant risk to the plan.

18.6.3. In addition, a further £4.7m of non-recurrent savings is projected. A high level scoping exercise has been undertaken and, subject to further development, this level of non-recurrent savings is considered to be achievable.

18.7. **Additional actions**

18.7.1. The plan identifies further actions totalling £8m. This includes £3m of forecast under spend for the period April-September in relation to core operational budgets, reflecting current trend and the expected phasing of remobilisation for services. A further £5m is expected to be delivered through corporate actions, including release of contingency reserves, review of balance sheet and flexibility on commitments within the plan. Plans for this level of flexibility have already been developed and this is not considered a significant risk.

18.8 **Key Risks**

18.8.1. A full risk assessment will be included with submission of the financial plan. Key risks to the plan are described in summary below:

- Remobilisation of services will be dependent on the phasing of vaccination programme delivery and consequent impact on the level of COVID-19 incidence within the region. This creates a significant level of uncertainty around the phasing of expenditure plans and in relation to demand for COVID-19 service provision.
- Recovery of performance against Access standards – no provision is made in the plan for additional resource requirements to recover performance against access standards.
- Mental health & wellbeing – no provision is made in the plan for additional actions required to address the emerging impact of COVID-19 on mental health and wellbeing.

- Primary Care Investment – the board's Primary Care Improvement Plan (PCIP) has identified a shortfall in resources required to fully implement the commitments outlined in the GP contract memorandum of understanding. Particular areas of financial risk are in relation the development of board capacity to delivery vaccination programmes and the implementation of CTAC.
- Identification and implementation of recurring savings plans will be dependent on the ability of the board to remobilise its turnaround programme.
- No detailed assessment has been made in relation to resources required to address wider health inequalities impact of the pandemic.

Longer Term Priorities

19.1 **Local**

19.2. There are a number of planning assumptions as a result of the pandemic which will require a new timetable of work and the reshape and launch of a new Renew Programme which will help the organisation re-set priorities and also reaffirm the direction of travel.

19.3. These are outline below:

- The 2020/21 plan will be carried forward to 2021/22 in relation to projects and areas of work that have been paused
- The pandemic will have had an impact on the efficiency of services
- We will continue to need staff to be redeployed to support our COVID-19 response functions and high priority services
- We will continue to operate all functions with social distancing
- We will need to continue with new ways of working implementing lessons learned
- There some areas with increased levels of activity or backlog that may remain for a period of time
- There will be a loss of income for some income generation services
- Schemes that require Capital may not be deliverable due to the need to reprioritise capital monies

19.4. The assessment and engagement with our staff and key partners is hoped to start during March in order to develop priorities moving forward, this will include individual assessment with service areas as delivery outcomes may now not be viable because of changes in service delivery and will also allow us to progress and implement lessons learned. This vital planning work will underpin and support a launch of a renew programme for NHS Borders during June 2021.

19.2. **Developing a Green Recovery**

19.2.1 The Scottish Government published its updated Climate Change Plan in December 2020, which included a commitment to a 'green recovery' from COVID-19. This commitment builds on the public sector commitment to meet carbon neutral targets by 2045.

19.2.2 In order to develop our response to this challenge and to ensure we learn from the positive aspects of changes implemented during the pandemic, we will establish a Climate Change Sustainability group within three months with a view to publishing a Sustainability Development Action Plan by December 2021.

19.3. **Regional**

19.3.1 Cancer

19.3.2. The Regional Cancer Surgical Prioritisation Group continues to support the SCAN Boards (NHS Lothian, Fife, Borders and Dumfries and Galloway) with the regional implementation of the ***Framework for Recovery of Cancer Surgery*** *(July 2020)* and the ***National Approach to Clinical Prioritisation*** as set out in the Scottish Government letter in July 2020. These documents provide NHS Scotland with guidance for the recovery of cancer surgery whilst ensuring appropriate COVID-19 safety measures are in place. The guidance sets out the following principles:

- Identify and prioritise patients appropriately
- Maintain equitable access to care for patients across NHS Scotland
- Deliver care in the safest possible environment
- Ensure a consistent national approach to clinical prioritisation for elective activity, while allowing for flexibility to reflect local circumstances

19.3.3. The Regional Cancer Surgical Prioritisation Group meets monthly with a remit to:

- Ensure all MDTs apply the same clinical prioritisation for all patients listed for surgery, including cancer, and as identified in the **Clinical Guide to Surgical Prioritisation during the Coronavirus Pandemic** that has been jointly developed by the Surgical Royal Colleges across the UK
- Provide an escalation route for NHS boards' local clinical prioritisation groups for any issues that require regional working
- Facilitate cross-board working where required, which may require the transfer of patients or staff, or both, to adjacent and/or co-located boards within the region
- Inform the Regional Cancer Planning Group, the National Cancer Treatment Group and National Cancer Recovery Group of local or regional service pressures and when local and regional solutions are not immediately available
- Cascade any national and regional communications within their own board as required

19.3.4. The Regional Cancer Recovery Dashboard is made available to boards' service management teams and will continue to inform recovery planning and monitoring of the delivery of cancer services across the SCAN Boards. The dashboard brings together the latest data available from Audit and Cancer Waiting Times sources on the Detecting Cancer Early (DCE) tumour groups - Lung, Colorectal and Breast. This presents a suite of indicators which captures the demand for cancer services across the region and compares trends by cancer type. Updates to the dashboard are released on a monthly basis with ChemoCare and Radiotherapy data to be added as well.

19.4. Health Protection

19.4.1. Health Protection services are an integral part of NHS Board's Public Health function, with multidisciplinary teams in each Board protecting citizens through surveillance, investigation and control of communicable disease and non-infectious environmental hazards. The COVID-19 global pandemic has put significant pressure on Health Protection services in maintaining this essential 24/7 service, with recognition that there are elements duplicated across all Boards which have the potential to be coordinated and delivered more sustainably through a regional model.

19.4.2. NHS Fife, Borders, Lothian and Forth Valley are exploring options for a regional Health Protection model which will support sustainability and resilience and have in place a function that is fit for the future and designed to respond effectively to 21st Century Health Protection challenges.

19.4.3. A formal appraisal of options will be undertaken during March with involvement of Health Protection professionals from each Board including Partnership representation. The outcome of the Options Appraisal will be presented to Boards for consideration at the end of March 2021.

19.5. Innovation in Mental Health

19.5.1. The regional innovation collaboration, Health Innovation South East Scotland (HISES), is leading on the development of Mental Health innovation challenges over the next 24 months, recognising the priority status of mental health in remobilisation and recovery planning. This work will be supported by dedicated clinical leadership in each Board and a project management resource.

19.5.2. This recent initiative has commenced a programme of engagement with regional specialist mental health services to scope key innovation challenges with mental health services in Perinatal Mental Health, Specialist CAMHS, Eating Disorders and Learning Disabilities with a range of service delivery constraints identified. These will be collated and developed as part of the innovation challenge development process.

19.6. **And Finally...**

19.6.1. The COVID-19 pandemic being the most challenging period NHS Borders has faced, and continues to face. There is a need for the organisation to pause and take stock of the challenges ahead. Work is underway to develop a detailed action plan that underpins the position we have described in this iteration of our Remobilisation Plan. This action plan will form the basis of the next iteration of our 2021/22 plan and will also inform our longer term planning assumptions.

Appendix 1

NHS Borders Recovery Assumptions, Principles, Conditions, high level Constraints

1. Recovery Assumptions:

Respond:

- COVID with us for the next 12-18 months
- Services provided in a way to meet circumstances
- Testing & contract tracing is key requirement
- Physical distancing, shielding, isolation & use of PPE will remain
- Agreed COVID 19 surge capacity as per mobilisation plan (Acute 89 – 156 beds / ITU 20 beds) to be reviewed on a regular basis (subject to reduction of non COVID-19 activity)
- Ability to stand up / down services – ability to surge bed numbers at short notice based on agreed triggers
- Workforce levels & skill set clear
- Mutual aid to partners (regional, care homes etc)
- Director of Nursing accountability for provision of leadership and guidance to all care homes & care at home

Recover:

- Identify & agree priority services & patient groups for recovery
- Clinically-led prioritisation for re-establishing services
- Elective patients need to be treated safely in line with national guidelines
- Working in partnership with social work & social care services to engage with elective patients pre-hospital
- Opportunity to address inequalities
- Some services centrally mobilised – staff deployment hub, centrally managed of PPE & Infection Control
- Wellbeing of our staff underpins everything we do – support our staff

2. Recovery Principles:

- System-wide, safe and person centred services
- Clinical prioritisation
- Agile, flexible and responsive system
- Realistic care provided locally, regionally, nationally as clinically appropriate
- Protecting our workforce
- Digitally enabled
- Data enabled
- Staff (as per standards) & public engaged
- Equity of access
- Human Rights focused responses

3. Recovery Conditions:

- Data Modelling
- Testing Strategy
- Clinical Prioritisation Model & Approach
- Joint working across the whole system
- Development of a Workforce Strategy/Resources Strategy/Model
- Expansion of the Digital Platforms
- Clear leadership/Decision making
- Services to respond within stated parameters

4. Recovery High Level Constraints:

- Maintaining management of COVID-19 across the whole health & care system
- Addressing patient & family concerns, maintaining confidence for users of services & supporting attendance/access to services (e.g. shielding patients)
- Undertaking & maintaining public & stakeholder engagement
- Need to maintain physical distancing (space constraints)
- Workforce - capacity, productivity, concerns, absence & wellbeing
- Supply Chain demands (PPE & high usage items)
- IT capacity, infrastructure & cost
- Organisational capacity
- Testing turnaround & results
- Impact of contact tracing
- Rapidly changing national guidance/requirements
- Legislative requirements
- Financial resources - cost, finite, lost activity & increasing demand, new services, financial turnaround, national funding & Health & Social Care impact