Borders NHS Board

A meeting of the Borders NHS Board **will be held on** Thursday, 7 December 2023 **at 9.00am at Lecture Theatre, Education Centre and via MS Teams (HYBRID)**

AGENDA

Time	No		Lead	Paper
9.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
9.01	**2**	**REGISTER OF INTERESTS**	Chair	*Appendix-2023-95*
9.02	**3**	**MINUTES OF PREVIOUS MEETING** 05.10.23	Chair	*Attached*
9.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
9.05	**5**	**STRATEGY/WORKFORCE**		
9.05	5.1	Emergency Department Workforce Review	Chief Officer Health & Social Care	Appendix-2023-96
9.25	5.2	Mental Health and Learning Disabilities Medical Workforce Plan	Chief Officer Health & Social Care	Appendix-2023-97
9.45	**6**	**FINANCE AND RISK ASSURANCE**		
9.45	6.1	Resources & Performance Committee minutes: 07.09.23	Board Secretary	Appendix-2023-98
9.46	6.2	Endowment Fund Board of Trustees minutes: 07.08.23	Board Secretary	Appendix-2023-99
9.47	6.3	Finance Report	Director of Finance	Appendix-2023-100
10.05	**7**	**QUALITY AND SAFETY ASSURANCE**		
10.05	7.1	Clinical Governance Committee minutes: 13.09.23	Board Secretary	Appendix-2023-101
10.06	7.2	Quality & Clinical Governance Report	Director of Quality & Improvement	Appendix-2023-102

10.20	7.3	Infection Prevention and Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2023-103
10.35	7.4	Public Protection Annual Report	Director of Nursing, Midwifery & AHPs	Appendix-2023-104
10.45	**8**	**ENGAGEMENT**		
10.45	8.1	Public Governance Committee minutes: 10.08.23	Board Secretary	Appendix-2023-105
10.46	8.2	Area Clinical Forum Minutes: 15.08.23	Board Secretary	Appendix-2023-106
10.47	**9**	**PERFORMANCE ASSURANCE**		
10.47	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2023-107
10.57	**10**	**GOVERNANCE**		
10.57	10.1	Consultant Appointments	Director of HR, OD & OH&S	Appendix-2023-108
10.58	10.2	Scottish Borders Health & Social Care Integration Joint Board minutes: 20.09.23	Board Secretary	Appendix-2023-109
10.59	**11**	**ANY OTHER BUSINESS**		
11.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 1 February 2024 at 9.00am at **Lecture Theatre, Education Centre & MS Teams (HYBRID)**	Chair	*Verbal*

Borders NHS Board

Minutes of a meeting of **Borders NHS Board** held on Thursday 5 October 2023 at 9.00am at Kelso Tait Hall, Kelso.

Present:
Mrs K Hamilton, Chair
Ms S Lam, Non Executive
Mrs H Campbell, Non Executive
Mr J Ayling, Non Executive
Cllr D Parker, Non Executive
Mr J McLaren, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Dr S Bhatti, Director of Public Health

In Attendance:
Miss I Bishop, Board Secretary
Mr A Carter, Director of HR, OD & OH&S
Mrs L Jones, Director of Quality & Improvement
Mr C Myers, Chief Officer Health & Social Care
Mrs S Errington, Head of Planning & Performance
Mrs C Anderson, Child Health Commissioner
Miss L Henderson Communications Officer
Mr S Whiting, Infection Control Manager
Mrs A Wilson, Director of Pharmacy
Mrs C Park, Deputy Director of Pharmacy
Mrs C Oliver, Head of Communications & Engagement

1. Apologies and Announcements

1.1 Apologies had been received from Mrs F Sandford, Non Executive, Mrs L O'Leary, Non Executive, Mr T Taylor, Non Executive, Dr K Buchan, Non Executive, Mr G Clinkscale, Director of Acute Services, Mrs S Horan, Director of Nursing, Midwifery & AHPs, and Mrs J Smyth, Director of Planning & Performance.

1.2 The Chair welcomed a range of attendees to the meeting as well as the public and press.

1.3 The Chair announced that the Public Health Team had undertaken a "Working Together to Tackle Health Inequalities" event on Monday 2 October which was very well attended.

1.4 The Chair announced that the Independent National Whistleblowing Ombudsman (INWO) had issued a Whistleblowing Complaint Report relating to NHS Borders. The report had been published on the NHS Borders website on 20 September. NHS Borders had adopted the new National Whistleblowing Standards for the NHS in Scotland on 1 April 2021 and welcomed its introduction to provide staff, students

and volunteers with a means of speaking up about perceived wrongdoing. NHS Borders had taken learning from the INWO's findings within the report and was working hard to ensure that its approach to handling whistleblowing cases complied fully with the new Standards.

1.5 Mrs Sonya Lam, Non Executive Whistleblowing Champion commented that the current week was national "Speak Up" week and all Health Boards had a whistleblowing champion. The role of the champion was to provide assurance, promote and provide a safe space for people to raise concerns. The promotion of confidential contacts to staff had taken place across the week and Mr John McLaren had been supporting staff sessions across various sites across NHS Borders.

1.6 The Chair confirmed the meeting was quorate.

2. Declarations of Interests

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

The **BOARD** noted there were none declared.

3. Minutes of the Previous Meeting

3.1 The minutes of the extraordinary meeting of Borders NHS Board held on 17 August 2023 were approved.

4. Matters Arising

4.1 **Action 2023-4:** The action remained live.

4.2 **Action 2023-6:** The item was a substantive item on the meeting agenda that day.

The **BOARD** noted the Action Tracker.

5. Risk Management Policy

5.1 Mrs Laura Jones provided an overview of the content of the report. She advised that it set out the role and responsibilities of the Board across the organisation for risk and the systems that the staff should follow.

5.2 The Chair suggested on page 20 that in terms of completeness it should relate to the Health and Safety Team to link to individuals and Mrs Jones agreed to make that amendment.

5.3 Mrs Sonya Lam asked that the Whistleblowing Governance Group be included on the risk architecture. Mrs Jones agreed to update the risk architecture accordingly.

5.4 Further discussion focused on: assurance framework being taken forward in line with the second edition blueprint; communication plan to roll out the revised policy to staff; strategic risks on population health are captured; and the risk management system is across the whole organisation.

The **BOARD** approved the Risk Management Policy.

6. Children's Rights Report 2020-2023 & Action Plan 2023-2026

6.1 Dr Sohail Bhatti introduced the report and Mrs Carole Anderson provided an overview of the content and highlighted the plans for the following 3 years going forward.

6.2 Mrs Harriet Campbell commented that she was disappointed that climate change was not mentioned within the report. Mrs Anderson advised that she would revisit the report in terms of climate change.

6.3 Further discussion focused on: on-line training; engagement with staff on children's rights; given the amount of output and activity what impact is seen and how is it measured; the plan for 2023-2026; all outcomes will focus on the differences being made; and a complaints procedure for children and young people will be put in place in 2024 to glean feedback from our population of children and young people.

The **BOARD** noted the report.

7. Primary Care Improvement Plan Annual Programme Report

7.1 The Chair commented that the Primary Care Improvement Plan (PCIP) contained a wealth of information for the Board and the purpose in bringing the report to the meeting was for the Board to seek assurance that the decision it had made in August to pump prime, was gaining traction.

7.2 Mr Chris Myers highlighted several key elements within the annual report including: Scottish Government funding shortfall for PCIP in vaccination transformation and the wider plan; bids for demonstrator sites and phased investment to test the full delivery of MoU 2; sustainability of primary and community services and delivery of GP contract; working with GPs; savings associated with polypharmacy review; and progress of CTAC proposal.

7.3 Discussion focused on several elements including: whole system approach; sustainability of primary care; impact of the renew service; work of first contact physios in the community; workforce challenges; 10% vacancy rate in GP practices; demonstrator sites expected to be funded to March 2025; recruitment challenges; financial risk and the ability to withdraw if value is not being delivered.

The **BOARD** noted the content of the report and considered the issue raised.

8. Resources & Performance Committee minutes: 04.05.23; 17.08.23

The **BOARD** noted the minutes.

9. Endowment Fund Board of Trustees minutes: 15.05.23

The **BOARD** noted the minutes.

10. Audit & Risk Committee minutes: 14.06.23; 24.07.23; 10.08.23

The **BOARD** noted the minutes.

11. Final Patient's Private Funds Accounts 2022/23

11.1 The papers were not shared with the public as they formed part of the Health Board Annual Report and Accounts that would be made public once laid before the Scottish Parliament in the autumn.

11.2 Mr Andrew Bone commented that the Board was required to account for patient's private funds as part of the group accounts of the Board. Due to audit timing they had not been available at the June meeting. He confirmed that the accounts had been given a clean audit opinion.

11.3 Mr James Ayling, Chair, Audit and Risk Committee commented that the Audit and Risk Committee had reviewed the accounts and were happy to recommend the Board approve them.

The **BOARD** approved the Annual Accounts for Patients' Private Funds.

12. Audit & Risk Committee Chair Update Report

12.1 Mr James Ayling highlighted two items of concern to the Board namely, use of agency and bank staff and IT resilience recovery.

12.2 Mr Andrew Bone provided an update on the status of the previous two items escalated to the Board namely, property transactions and ventilation. He advised that the property transaction recommendations had been fully completed and there was still some active work taking place in regard to the ventilation recommendations.

12.3 Mr Ralph Roberts suggested an action be placed on the action tracker for the Board to receive an update from the Audit & Risk Committee to confirm progress had been made with the IT resilience recovery recommendations. Mr Ayling reminded the Board that it received the annual assurance report and the minutes of the Audit & Risk Committee and he suggested that as the route for the Board to receive assurance that progress was being made. The Chair suggested the matter be considered further.

12.4 Further discussion focused on: TOM for digital services and assurance through the Resources and Performance Committee; progress on bank and agency recommendations through performance meetings; implementation of erostering; use of the audit process when we know there is an issue allows the generation of a no assurance report which in turn ensures action is taken; and what other issues are there.

The **BOARD** noted the report.

13. Finance Report

13.1 Mr Andrew Bone provided an overview of the report and highlighted: original forecast of £22.5m and current forecast of £26.1m; actions to address the deficit; Quarter 2 review report to the Board in December; figure 1 para 3.6 describes

improvement month on month; operational drivers; financial recovery actions; savings plans with £1.8m delivered against a target of £5; and key risks and national reporting of primary care prescribing data lag.

13.2 Discussion focused on: value based health care and over prescribing; Scottish Government financial tailored support; over medicalisation of society; make healthier choices easier; public expectation in relation to their health and health care system; clinicians expectations on how they deliver health services; and working with the public around expectations and perceptions.

The **BOARD** noted that the board was reporting an overspend of £11.07m for five months to end of August 2023.

The **BOARD** noted the position reported in relation to recurring savings delivered year to date.

The **BOARD** noted there was no change to the updated outturn position of £26.1m following completion of the Q1 review and that the forecast would be reviewed as part of the Q2 review taking place during October.

14. Clinical Governance Committee minutes: 24.05.23; 15.08.23

The **BOARD** noted the minutes.

15. Quality & Clinical Governance Report

15.1 Mr Laura Jones provided an overview of the content of the report and highlighted: three inspections had taken place in relation to children and harm, medicines and health care in relation to blood banks, and HIS ionising radiation and nuclear medicine; risks in relation to dental services; data gaps in community services; delays across the whole health and care system and the impact on the ability to access specialist beds; risk around haematology and dermatology services; psychiatry hotspots in terms of clinical gaps in the psychiatry workforce across NHS Scotland; increase in complaints received; and covid inquiries.

15.2 During discussion several subjects were raised including: the dental team had been expanded and was performing well in Borders for dental access which was a national issue; dermatology posed a significant risk with urgent work being addressed but significant waits for those with routine review appointments; the mental health service remained of severe concern with the loss of 3 consultant psychiatrists and a fourth about to leave to move to Australia; and the relentless pressure that staff were under especially in the Emergency Department.

The **BOARD** noted the report.

16. Infection Prevention & Control Report

16.1 Mr Sam Whiting drew the attention of the Board to two areas within the report: page 8 section 6 hand hygiene, where the last round of audits had been completed and compliance rates had increased to 66% and an improvement in glove usage from 76% to 88%; and page 11 acknowledging the on-going impact of covid, some wards in the Borders General Hospital and Community Hospitals were affected.

16.2 Further discussion ensued which included: an explanation of the impact of an outbreak of covid on wards and how it is managed; the importance of being in hospital for medical reasons and for being discharged as soon as any medical issues were addressed; NHS Borders continues to test for covid on admission which is outwith national guidance; the impact on individuals in terms of unnecessary multiple infections due to multiple moves because they are delayed discharges; and surgical site infection processes.

The **BOARD** noted the report.

17. Pharmacy Aseptic Service

17.1 Mrs Alison Wilson provided an update on the Pharmacy Aseptic Service and the progress that had been made since the last update provided to the Board in June. She advised that NHS Lothian would pursue licencing options and had asked for a list of the products to be manufactured.

17.2 Mrs Cathryn Park, Deputy Director of Pharmacy provided an update in terms of risk mitigations, recruitment, skill mix in the unit, newly qualified staff opportunities, unit infrastructure and the continuation of mutual aid provision by NHS Forth Valley to NHS Borders, NHS Fife and NHS Lothian.

17.3 Discussion focused on: previous advice that a licence was not required; thanks to Mrs Park for taking on the responsible pharmacist role; suspension of the national aseptics programme; timeline for infrastructure assessment; key risk around ventilation as the unit closes in winter if it is too cold or too windy; timeline for delivery; funding is likely to be the next financial year; the risk is contained on the risk register and has been through the appropriate risk process; NHS Lothian is committed to an aseptic unit in their new cancer centre which will be licenced for a wide range of products for the east region; the project group contains partnership representatives as well as close links to the Macmillan centre; there was often a reliance on individuals to maintain a service; there were constraints on space in the pharmacy department and it would be challenging to make the space fit for purpose; and the provision of capital resource to deliver on projects was overprescribed.

The **BOARD** noted the report.

18. Staff Governance Committee minutes: 31.03.23; 20.07.23

The **BOARD** noted the minutes.

19. Public Governance Committee minutes: 15.06.23

The **BOARD** noted the minutes.

20. Area Clinical Forum Minutes: 23.05.23; 27.06.23

The **BOARD** noted the minutes.

21. NHS Borders Performance Scorecard

21.1 Mrs Steph Errington provided an overview of the content of the report and highlighted that the trajectory targets for outpatients, emergency care and mental health waiting times could not be met. Actions and key mitigations had been put in place across those areas to improve that performance where possible.

21.2 Mr Ralph Roberts commented that he had met with Mr John Burns at the regular 6 monthly performance meeting and Mr Burns had been assured that NHS Borders was aware of its issues and was taking the right course of action to address those issues.

21.3 Mrs Sonya Lam enquired how confident Mr Roberts was in terms of the sustainability of NHS Borders. Mr Roberts suggested he was keen to move to the longer term discussion on what NHS Borders shape and scale of service would look like taking into account the population demographic, rural location, and financial and workforce challenges of the future.

21.4 Mr Chris Myers provided an update on the current delayed discharges position. He advised that there were 83 delayed discharges waiting across the Borders General Hospital, Mental Health and Community Hospitals. He drew the attention of the Board to the trajectory that had been agreed at the Resources & Performance Committee on page 9 of the report, which outlined the direction of travel in regard to redesign work and additional capacity being commissioned through Scottish Borders Council. Whilst the target of 83 delays had been achieved slightly ahead of trajectory it was still high and it was important for the Board to know that the work being undertaken and the oversight of all actions on the surge plan were being progressed. The risks attached to each action on the action plan were regularly reviewed to ensure the actions remained deliverable.

21.5 Discussion focused on: cancer performance; the risk to patients of infection from being in hospital when they no longer needed medical intervention; impact of being a rural area in terms of workforce and population demographic; challenges in the provision of CAMHS services due to vacancies and maternity leave; successful recruitment to the psychologist post; skill mix in mental health services with senior trainee; CAMHS working to mitigate capacity issues; looking at how to develop the third sector and therapeutic services; and workforce challenges across the public sector.

21.6 The Chair recorded her thanks to Mrs Errington for her work and support in covering Mrs June Smyth's role in her absence.

The **BOARD** noted performance as at the end of August 2023.

22. Scottish Borders Health & Social Care Integration Joint Board minutes: 17.05.23; 19.07.23

The **BOARD** noted the minutes.

23. Annual Review letter

23.1 The Chair commented that she had met with the Minister earlier in the week and she had reflected to her how much she had enjoyed the Annual Review session in the Scottish Borders. She had reiterated to the Chair that she had been content

with the general sense of how NHS Borders was performing and its general interaction and standing within local communities.

The **BOARD** noted the report.

24. Board Business Plan

24.1 Miss Iris Bishop provided a brief overview of the content of the report.

The **BOARD** approved the Board meeting dates schedule for 2024.

The **BOARD** approved the Board Business Cycle for 2024.

25. Consultant Appointments

The **BOARD** noted the report.

26. Any Other Business

The **BOARD** noted there was none.

27. Date and Time of next meeting

27.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 7 December 2023 at 9.00am in the Lecture Theatre, Education Centre, Borders General Hospital and via MS Teams (hybrid).

Borders NHS Board Action Point Tracker

Meeting held on 29 June 2023

Agenda Item: Mainstreaming Report

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2023-4	7	The **BOARD** agreed to remit the report to the Public Governance Committee on 10 August for scrutiny with a commitment to publish the document immediately after the meeting.	**June Smyth Tris Taylor**	**In Progress:** The Public Governance Committee reviewed the document and provided comments and feedback at its meeting on 10th August. The Committee agreed that an updated version will be considered virtually by members before the document is published.

Agenda Item: Pharmacy Aseptic Service

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2023-6	23	The **BOARD** noted that a further report would be brought back to the Board in 6 months time seeking a decision.	**Alison Wilson Lynn McCallum**	**In Progress:** Update paper prepared for Board meeting on 5 October 2023. **Complete:** Paper presented to Board meeting 05.10.23.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Register of Interests**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive

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

- Person Centred

2 Report summary

2.1 Situation

2.1.1 The purpose of this report is to include the revised declarations of interest for Mrs Harriet Campbell in the formally constituted NHS Borders annual Register of Interests as required by Section B, Sub Section 4, of the Code of Corporate Governance.

2.2 Background

2.2.1 In accordance with the Board's Standing Orders and with the Standards Commission for Scotland Guidance Note to Devolved Public Bodies in Scotland, members are required to declare annually any private interests which may be material and relevant to NHS business.

2.3 Assessment

The Register of Interests is made up of details received from members regarding any private interests which may be material and relevant to NHS business and constitute the Register of Interests.

The Register is made publicly available both through the NHS Borders website and on request, from the Board Secretary, NHS Borders, Headquarters, Education Centre, Borders General Hospital, Melrose TD6 9BD.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Regulatory requirement.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable

2.3.7 Other impacts

Not applicable

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to **approve** the inclusion of the revised declarations of interests for Mrs Harriet Campell in the Register of Interests.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Declaration of Interests Mrs Harriet Campbell

Borders NHS Board

Register of Interests of Board Members

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

Board Member: HARRIET CAMPBELL….. *(please insert your full name in capital letters)*

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	Employee of Womble Bond Dickinson LLP, The Spark, Draymans Way, Newcastle Helix, Newcastle Upon Tyne NE4 5DE (Legal Director) Owner and Manager of holiday let, Little Hermitage, Kelso
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	-
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	Ongoing contract with NHS Borders to do laundry for above holiday cottage on standard commercial rates
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	-
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	-
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	-
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	Chair Borders Organ Donation Committee Chair, Kelso High School Parent Council. Member Borders-wide group of High School Parent Council Chairs.

Signed……Harriet Campbell…….. Date …27/10/23……...

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Emergency Department Workforce Review**
Responsible Executive/Non-Executive(s):	**Chris Myers, Director Health and Social Care, Laura Jones, Director of Quality and Improvement, Peter Lerpiniere, Acting Director of Nursing, and Lynn McCallum, Medical Director**
Report Author:	**Bhav Joshi – General Manager, Unscheduled Care**

1 Purpose

The purpose of this report is to:

- describe the unscheduled care pressures across the Borders General Hospital;
- describe the risks derived from these pressures, and explain areas of focus to mitigate these risks; and
- seek support with the planned future actions (incl. recommendations with appendix 1 – ED Workforce Review)

This is presented to the Board for:

- Awareness
- Decision

This report relates to:

- Annual Operational Plan/Remobilisation Plan
- Emerging issue

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Borders General Hospital has carried a significant level of risk in the Emergency Department (ED) for several years. During the overnight period, there is a less experienced medical team available to support and manage complexity. There are also reduced levels of wider medical support or expertise, and most significantly, there is a lack of mutual aid for the single armed senior decision maker. This is no longer tolerable. There is currently a risk on the risk register (1102 – graded High) regarding the lack of medical expertise in the overnight period. It reads that the ED is staffed by a single doctor between 00:00 and 08:00. For 26 weeks of the year, this doctor is rostered to be an Orthopaedic GP Specialty Trainee who could only have two years' medical experience and no experience in the ED.

As with the medical staffing issues above, the nurse staffing overnight has caused similar concern. Appropriate levels of nursing staff are essential in supporting and guiding the junior medical workforce. The core staffing (overnight) was previously 3 registered nurses and was unable to manage the volume and acuity of patients seen in the department. In order to mitigate this risk the Nurse in Charge of the hospital (Night Sister) was regularly 'warded' to ED to support the department clinically. This comprises flow and safety across the wider hospital.

The NHS Borders Board is recommended to:

- **Note** the significant safety issues detailed within this paper (and ED Workforce Review – Appendix 1; Sections 2.2 - Strategic Context, and Section 3.2 - Drivers for Change;
- **Note** the interim arrangements put in place since 2020 (including during the pandemic) which are not substantively funded;
- **Support** the planned future actions (incl. plan to develop a strategic vision for urgent care pathways;
- **Support** the recommendations/preferred option described within the ED Workforce Review – Appendix 1 and
- **Agree** that the future model of delivery in the ED will need to be further considered in line with the acute services strategy, and the unscheduled care programme.

2.2 Background

The ED is carrying significant risk in the out of hours period due to the concerns described in the Situation (above). To meet the significant pressures which have arisen due to the pandemic, the core ED footprint has expanded to accommodate additional activity. This has required additional workforce, and the level of core staffing has become flexible to accommodate an increased footprint and workload.

The current workload in ED for both core and non-core activity has resulted in a persistent period of pressure derived from several complex issues.

The signs of the current challenges are clear with sustained pressures in the community, long waits in the ED, increased turnaround times for ambulances and the significant real time risks for those who are unable to access timely assessment due to capacity and workforce issues. These impacts can adversely affect patients with longer inpatient stays, higher rates of mortality and higher costs of care. Nationally, there continues to be significant challenges across both health and social care as systems attempt to meet the 4-hour emergency access standard as shown below:

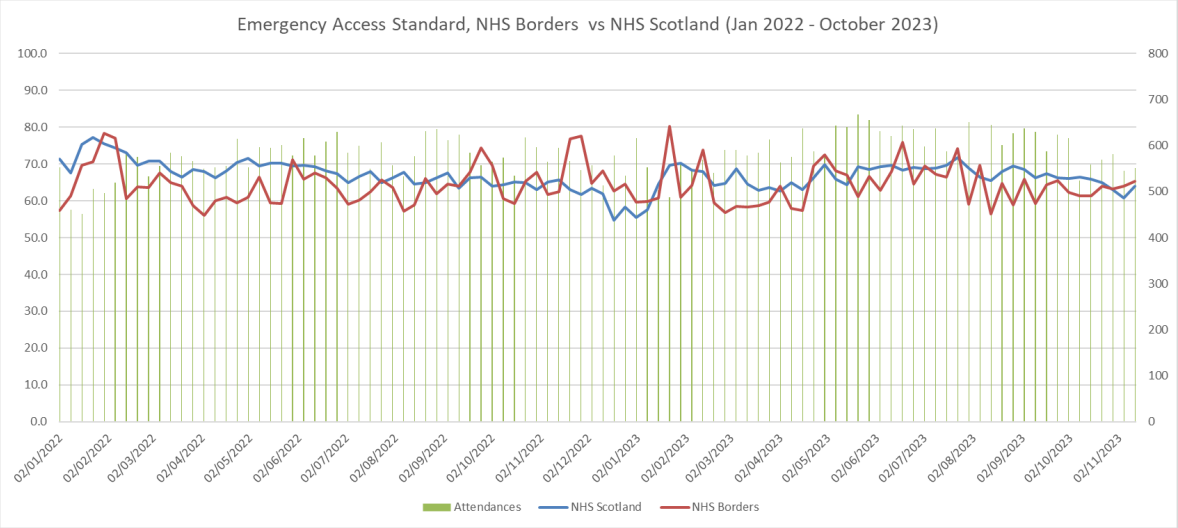

Figure 1 - Emergency Access Standard, NHS Borders vs Scotland

Covid-19 has magnified existing concerns and challenges for health services, and the challenges this has brought are well understood by the NHS Borders Board. For the ED, longer than average waits for IP beds increases the instances of the department becoming overcrowded: the risks to patient safety and the adverse consequences on patient and staff experience are well known and documented/evidenced. It is difficult to maintain a clear view of the patients in the department when spaces are overcrowded, infection control and health and safety standards are more difficult to maintain with delays and omissions of care and treatment. These difficulties are exposed further during the overnight period when staffing is compromised.

Senior decision-making, and Nursing capacity during these periods is crucial in decongesting the department, making rapid decisions as to patients that can sit out or who can be deemed a lower priority, and providing a response to periods of high activity/volume.

The Whole System Winter Response 23/24 is concerned with decongesting the hospital and the principal aim in ED is to close non-core ED footprint return key urgent care pathways such as GP Expect (non-core ED activity) to their original location or alternative. This paper does not consider the workload or new location of the GP expect pathway.

2.3 Assessment

The Borders General Hospital has carried a significant level of risk in the ED for several years. Crucially, during the overnight period, there is a less experienced medical team available to support and manage complexity. There are also reduced

levels of wider medical support or expertise, and most significantly, there is a lack of mutual aid for the single armed senior decision maker.

There is currently a risk on the risk register (1102 – graded High) regarding the lack of medical expertise in the overnight period. It reads that the ED is staffed by a single doctor between 00:00 and 08:00 each night. For 26 weeks of the year, this doctor is rostered to be an Orthopaedic GPST who could only have two years medical experience and no experience in ED.

Interim Actions

Covid-19 has magnified existing concerns and challenges for health services, accelerated some trends, and presented new problems. It has also brought a wider sense of purpose and urgency to transformation, upended our understanding of good quality care, and has driven forward fundamental change as barriers to innovation have been removed and innovations that may have felt too radical have become the 'new normal'.

To improve the level of safety across ED several actions have been taken to mitigate the level of risk and stabilise the department:

- March 2020 – current;
    - Blue ED (also known as Blue Zone and ED2) was opened in 2020 as a response to the Covid-19 pandemic and creating separate flows for infected/non infected patients. However, given challenges associated with increased length of stay (of both delayed and non-delayed patients) and greater levels of acuity, the facility remains open as surge capacity (non-core ED footprint). Blue ED has no substantive medical, nursing, or clerical resource attached to it. It is expected that Blue ED will close shortly in line with the continued progression of the Delayed Discharge and Surge Plan, and the associated reduction of occupancy and associated pressure expected at the front door.
- March 2022- current
    - Additional Overnight Doctor - a second overnight doctor was introduced to the department in on a temporary basis via the allocation of an additional post from NES in early 22/23 to provide professional support to the substantive senior decision maker. There is currently no substantive funding for this additional overnight doctor.
- October 2022– ED Workforce Tool Completed
    - A review was commissioned to develop an appropriate workforce model to mitigate the risks derived from the three main drivers for change (and attached as appendix 1).
    - There are three main drivers for change for this review, and these are recorded as:
        1. Additional Medical Cover (Overnight) - there is a lack of mutual aid for the single armed senior decision maker.
        2. Skill Mix – a lack of appropriate levels of multidisciplinary team working across Medical and Nursing professional groups
        3. Clinical Risk – derived from 1 and 2 above.
    - The workforce tool was run during October 2022 to provide the basis for the revised workforce assumptions (described an Appendix 1). However,

the output from the workforce tool run was adjusted using professional judgement to exclude staffing related to non-core ED activity and footprint

- March 2023 – March 2024
  - Additional Senior Decision Maker – An additional locum consultant was appointed in December 2022 (initially as maternity leave cover) but extended to March 2024 to spread senior decision-making cover across the day period, provide much needed senior cover and increase supervision capacity for trainees. There is currently no substantive funding for this additional decision maker.

Planned Future Actions

The pressures across NHS Borders are intense, complex, and unsustainable (as described above). The deriving factors are multifactorial and represent a whole system responsibility and accountability. There are several additional actions that should be considered to sustain the current position, mitigate risk and support patient/staff experience.

- ED Workforce Review

  An ED needs to be underpinned by a robust workforce model to ensure: timely offloading of ambulances, triage, access to a senior decision maker, and care plan agreed. While there are wider system issues currently impacting performance and quality, addressing safe patient centered care will require an appraisal of the core current workforce model to ensure it remains fit for purpose going forward.

  The ED Workforce review considers short-medium term actions to secure a return to a more stabilised the core service for the Borders General Hospital. It makes recommendations based upon local intelligence, National benchmarking, and National workload tools. National Benchmarking in relation to Medical workforce is shown below in Table 1.

NHS Board	Population * *(data from ISD 2021/2022)*	Consultants in Post	Population per 1 Consultant
Ayrshire & Arran	366,800	16	22,925
Borders	**116,020**	**2**	**58,010**
Dumfries & Galloway	148,790	4.6 - 8	32,346-18,599
Fife	371,910	11	33,810
Forth Valley	306,000	10.5	29,143
Grampian	584,550	17.5	33,403
Greater Glasgow & Clyde	1,200,000	71.8	16,713
Highland	235,540	6	39,257
Lanarkshire	319,020	30.5	10,460
Lothian	858,090	37.4	22,944
Tayside	416,080	19.7	21,121

Table 1 - Medical Benchmarking

- NHS Borders Surge and Occupancy Plan

A new surge plan and associated delayed discharge trajectory has been approved by the Health and Social Care Partnership (HSCP) Joint Executive Team and considered by the NHS Borders Resource and Performance Committee. This is a complex plan, involving actions from across the HSCP, and there are a number of risks associated with this plan, but work will be undertaken by the HSCP Joint Executive Team to manage performance and risk as effectively as possible. The plan is currently delivering as expected and will effectively decongest the Acute and wider system, in doing so allow closure of additional surge activity (this surge includes Blue ED). This assumes that GP Expect activity currently operating out of ED will remain in the short-medium term pending the outcome of the surge and occupancy plan.

Strategic Vision for Urgent Care Pathways

The COVID-19 pandemic significantly disrupted urgent care pathways, leading to several challenges which included the displacement of established pathways to create new space to maintain infection control protocol and protect staff/patients. Medical Ambulatory Care (ACU), Acute Assessment for GP referrals (AAU) and Surgical and Gynaecology (GSAU) pathways were displaced at the beginning of the COVID pandemic to release inpatient capacity. Interim arrangements were put in place to maintain these pathways and Blue ED was opened for surge capacity (and long waits). It is reasonable to assume that once these pathways are reintegrated into front door services that a further review of the ED will be required to distribute resource to where it is most needed and separate out Urgent from Emergency Care.

A longer term Urgent and Emergency Care Resilience review is required to build towards the 2030 vision, as recently developed as part of the Board wide Urgent and Unscheduled Care Annual Review. This future review should expand upon the scope of the ED Workforce Review (Appendix 1), and consider roles across: allied health professionals, advanced paramedics, third sector et al.

It must be acknowledged that no single approach, model or intervention can address the very complex issues that impact an ED, or indeed the wider health and care system. Systems must adapt to their own challenges and be appropriate for their population, geography and local set up.

2.3.1 Quality/ Patient Care

Standards and Guidance help provide a framework in which each system should operate. An ED underpinned by a suitably skilled MDT workforce creates the conditions to minimise risk, improve safety and ensure a high quality of care. The recommendations within this paper provide a basis to build upon but primarily focus on stabilising quality of care and safety.

2.3.2 Workforce

An ED needs to be underpinned by a robust workforce model to ensure: timely offloading of ambulances, triage, access to a senior decision maker, and care plan agreed. While there are wider system issues currently impacting performance and quality, implementing the recommendations compliments the work already underway to improve staff wellbeing and experience.

2.3.3 Financial

Medical

The current funding for the ED supports one member of medical staff overnight. In the past year, a second doctor has been added to the overnight shift, achieved by adjusting other hospital rotas. This second doctor may be available from paediatrics, obstetrics, gynaecology, or general medicine staffing, causing inconsistency and instability in ED staffing. If staff from other rosters are unavailable, or required in their own speciality ED daytime medical staffing is reduced to roster two existing staff overnight. Sustaining this level of coverage requires ongoing support from the Deanery for additional posts in specialities other than ED. To ensure consistent and experienced staffing in the ED overnight, it is proposed to increase the funded establishment in ED as shown below (table 2). Additionally, there is a need for an extra consultant post to enhance senior decision-making capacity and clinical oversight in the department.

Nursing

The nursing workforce has been reviewed using both the nursing workforce tool and professional judgement. Using both methods, the whole time equivalency (wte) staffing arrived at 38.19 wte and 39.39 wte respectively. It was adjusted further to remove the impact of non core ED activity in terms of GP Expect and Surge Capacity (Blue ED) during the reference period.

To increase the capacity in the minor injury service the Emergency Nurse Practitioner hours have been increase from 15 hours per day to 23 hour per day and these hours will be targeted to meet periods of increased demand and support mitigating the risks of overcrowding.

Summary

Tables 2 below detail the breakdown in wte, and cost for both the current funded establishment and proposed staffing models.

	Current		Proposed	
	wte	£000s	wte	£000s
Medical	14.1	1,719	18.34	2,363
Nursing	22.75	1,275	32.01	1,720
ENP	3.38	212	4.39	275
Administration	1.5	55	2.59	93
Total	41.73	3,261	57.33	4,451
Increase in wte and cost			15.6	1,190

Table 2 - cost breakdown current vs. proposed

During this work, NHS Borders financial position has been at the forefront of the work carried out and the increase in recurring budget of £1.2m has been minimised as far as possible and only relates to the mitigation of the high risks on the risk register. The in-year financial position for ED is significantly overspent. This is due to a several factors which are related to non-core related ED activity and footprint- (above), as well as increased staffing required to ensure safety related to core-ED activity.

Should the Surge and Occupancy plan deliver as expected, the in-year overspend may be reduced.

2.3.4 Risk Assessment/Management

In addition, strategic risk 4681 "Whole System Flow" outlines the risk management process that is being undertaken to manage the broader issue relating to whole system flow. This risk has also been reviewed by the Clinical Governance Committee in their November meeting.

Currently a risk on the risk register (4397 – graded Very High) regarding long waits for beds greater than 4 hours and up to 40 hours, and due to levels of activity and demand the ED operating as a medical admission unit. This risk continues to be routinely reported to the Operational Planning Group as part of the Board risk management process.

Moreover, there is a currently on the risk register (4709 – High) relating to the current level of nursing knowledge and skills within the department due to a high turnover of experienced nurses. Local feedback is suggestive of reduced job satisfaction and higher levels of workload as the root cause.

There are risks already on the risk register referring to the opening of surge capacity without the appropriate level of staffing and/or the impacts of congestion in the department. In addition to the risks above, there are additional risks on the risk register: 4472 (High) and 4171 (High).

2.3.5 Equality and Diversity, including health inequalities

As this relates to staffing, and does not relate to a change in policy or practice, an Equalities and Human Rights Impact Assessment has not been undertaken.

We know there is a strong link between deprivation and health outcomes. We also know that national there are more ED attendances from disadvantaged groups. At this stage the research on the link between waits in Emergency Departments and the impact on health outcomes is expected but unclear. The University of Oxford are undertaking research across 20 Emergency Departments to establish any impacts and this is expected to be completed in Autumn 2025[1].

[1] University of Oxford. Nuffield Department of Primary Care Health Sciences. Waiting times in Emergency Departments: inequalities and impact on health outcomes (ED-WAITS). Available from: https://www.phc.ox.ac.uk/research/health-economics-research/ED-WAITS

2.3.6 Climate Change

There are no known climate change or sustainability impacts.

However it is worth noting that admissions to hospital are associated with increased carbon emissions and climate impacts. Increased admissions because of fewer staff are likely to lead to an increase in carbon emissions.

2.3.7 Other impacts

There are no other known impacts.

2.3.8 Communication, involvement, engagement and consultation

The table below summarises the stakeholders impacted by this proposal and the details of the engagement that has taken place with them to date and notes their support for this proposal:

Stakeholder	Engagement that has taken place
Medical	Discussions with key stakeholders from the Emergency Department Medical team have taken place, supported by the Clinical Lead for Emergency Medicine to understand their requirements and feed into any modelling to date.
Nursing	Discussions with key stakeholders from the Emergency Department Medical team have taken place, supported by the Clinical Nurse Manager and Senior Charge Nurse for Emergency Medicine to understand their requirements and feed into any modelling to date. The Clinical Nurse Manager for ED changed twice during the period in which this review was developed due to retiral and vacancies.
Finance	The Deputy Director of Finance has been involved from the very outset of this work helping shape financial viability, the case for change and options for sustainability.
Management	The Senior Leadership Team, alongside Executive team have been engaged in this review with it first being commissioned in 2022. It is a key deliverable in achieving the safety standards required of the ED at the BGH. The Associate Medical Director, General Manager, Associate Director of Nursing and wider team have been sighted on developments throughout the process.

2.3.9 Route to the Meeting

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

- Acute Quad - 22 June 2023
- Operational Planning Group – 18 September 2023
- NHS Borders Executive Team – 3 October 2023
- Joint Executive Team – 28 November 2023
- NHS Border Health Board – 7 December 2023

As this relates to Acute Hospital Set Aside, the Scottish Borders Health and Social Care Integration Joint Board will also consider this paper in January 2024

2.4 Recommendation

NHS Borders Board is recommended to:

- **Awareness**
  - **Note** the significant safety issues detailed within this paper (and ED Workforce Review sections 2.2 - Strategic Context, and Section 3.2 - Drivers for Change);
  - **Note** the interim arrangements put in place since 2020 (including during covid) which are not substantively funded;
- **Decision**
  - **Support** the planned future actions and strategic vision for urgent care pathways;
  - **Support** the Recommendations/preferred option described within the ED Workforce Review); and
  - **Agree** that the future model of delivery in the ED will need to be further considered in line with the acute services strategy, and the unscheduled care programme.

3 List of appendices

The following appendices are included with this report:

- Appendix 1- ED Workforce Review
- Appendix 2- Unscheduled Care Surge Planning and Delayed Discharge Trajectory Update

NHS Borders

Emergency Department

Workforce Review

June 2023

Contents

0. Description of Figures and Tables

1. Executive Summary

The Emergency Department (ED) at the Borders General Hospital is a District General Hospital and provides care for the Borders population of 115,000. It is situated centrally in Melrose in the Scottish Borders. The ED provides 24/7 care for patients across all age groups and receives 30,000 annual attendances.

An ED needs to be underpinned by a robust workforce model to ensure: timely offloading of ambulances, triage, access to a senior decision maker and care plan agreed. While there are wider system issues currently impacting performance and quality, addressing safe patient centered care will require an appraisal of the current workforce model to ensure it remains fit for purpose.

Continued levels of high bed occupancy, coupled with notable increases across length of stay and occupied bed days (derived from delayed and non-delayed patients) has meant that patients have a longer than usual wait for a bed in the main inpatient (IP) footprint of the hospital. This increases the care and medical oversight required from key personnel across the ED including medical, nursing, and allied health professional groups.

Crucially, during the overnight period, there is a less experienced medical team available to support and manage complexity. There are also reduced levels of wider medical support or expertise, and most significantly, there is a lack of mutual aid for the single armed senior decision maker. This is no longer tolerable.

An appropriate ED workforce is a crucial factor in the provision of safe, effective, patient centered, quality emergency care. This requires a balanced team of nurses, doctors, allied health professionals, and support staff with the appropriate knowledge and skills.

There are three main drivers for change for this review, and these are recorded as:

1. Additional Medical Cover (Overnight) - there is a lack of mutual aid for the single armed senior decision maker.
2. Skill Mix – a lack of appropriate levels of multidisciplinary team working across Medical and Nursing professional groups
3. Clinical Risk – derived from 1 and 2 above.

This review has been commissioned to develop an appropriate workforce model to mitigate the risks derived from the three main drivers for change.

In developing a long list of options for review, two approaches where considered:

1. Workload tool – The workload tool is a Nationally approved approach to cross reference departmental staffing requirements. The tool takes into consideration the current pressures across the area in scope.
2. Professional judgement – this approach took the findings of the workload tool analysis and brought key multi-disciplinary/professional groups together to consider workforce models against recruitment viability, financial viability and risk context.

While Surge Staffing is considered out with scope of the review, core operations and surge are intrinsically linked. Therefore, recommending a proposed future workforce without recognising the need to consider surge staffing would pose an additional risk; namely that during periods of extremis there would be an inability to staff (either nursing or medical) surge capacity to manage patient

safety. Therefore, in line with the recommending workforce model, consideration should be given to:

- providing surge staffing from April 23 until 31 March 2024 at an annual cost of £516k;
- ensuring the required resources are part of a comprehensive implementation plan; and
- close monitoring of improvement work designed to reduce system wide pressures including the recently agreed delayed discharge trajectory (as part of the surge and occupancy winter plan);

The preferred option for Medical, Nursing and Clerical Roles in the ED is shown below.

Option	Description	Cost of Preferred Model £000s
Medical		
Option 3	EM consultant (3 WTE) Monday – Friday (supported by current in hours daytime rota) and 2 Doctors on night duty	£2,363
Nursing		
Option 3	Days (in-hours) 1 WTE SCN, 5 RGN, 1 HCSW Night (out-of-hours) 4 RGN night duty, 1 HCSW nights	£1,720
ENP		
Option 2	Cover from ENP 9am-9.30pm and additional ENP 8hrs per day 7 days per week	£275
Admin and Clerical		
Option 2	1 clerkess 9-9.30pm 7 days per week	£93
Total	Cost of preferred model	£4,451
Total		
	Cost of Current Model	£3,261
	Increased cost of preferred model	£1,190

It must be acknowledged that no single approach, model or intervention can address the very complex issues that impact an ED, or indeed the wider health and care system. Systems must adapt to their own challenges and be appropriate for their population, geography and local set up.

Standards and Guidance help provide a framework in which each system should operate. Above all, focused activity must be derived from evidence based best practice to ensure the ED remains as *safe as possible*. Good governance, underpinned by a robust and engaged workforce is the key to ensuring ongoing oversight and safe practices are maintained across the ED.

This workforce review recommends the preferred options above are supported at a total cost of £4,451k offset by £3,261k leaving a residual requirement of £1,190k. This increase relates to core staffing of ED only and any surge capacity will be required to be considered separately.

The Winter Plan 23/24 is primarily concerned surge and occupancy planning; permanently stepping down surge capacity by offsetting acute bed capacity with community capacity. This winter plan would allow the surge in ED to close around December which would mean that the cost of surge April to December 23 would be £365k There remains significant risk associated with the winter plan

as the stepping down of surge capacity across acute services is predicated upon realisation of a delays trajectory which remains ambitious and should it not be possible to deliver the closure of surge as forecast, a further £151k would be required to fund the surge in ED between January and March. This would then remain under review.

2. Purpose and Context

2.1 Introduction

NHS Borders is currently experiencing a prolonged and persistent period of pressure derived from a number of complex issues. The signs of the current challenges are clear with sustained pressures in the community, long waits in the emergency department (ED), increased turnaround times for ambulances and the significant real time risks for patients who are unable to access timely assessment due to capacity and workforce issues.

These impacts can adversely affect patients with longer inpatient stays, higher rates of mortality and higher costs of care *(Gaughan et al., 2020)*. Nationally, there continues to be significant challenges across both Health and Care as systems attempt to recover from the aftermath of the Covid-19 pandemic and traditional Winter pressures.

Covid-19 has magnified existing concerns and challenges for health services, accelerated some trends and presented new problems. It has also brought a wider sense of purpose and urgency to transformation, upended our understanding of good quality care and has driven forward fundamental change as barriers to innovation have been removed and innovations that may have felt too radical have become the 'new normal'.

This context has made the review of traditional workforce models a necessity to underpin the required level of safety across the system.

The purpose of this review is to:

- describe the unscheduled care pressures across the BGH, with particular reference to the Emergency Department;
- describe the risks derived from these pressures;
- present a number of considered options for a future workforce model to better mitigate the risks identified; and
- seek approval from the NHS Borders Board to accept the recommendations presented in Section 7

2.2 Strategic Context

The health and social care needs of a population are complex and this has been seen throughout the post pandemic period where patients presenting to emergency departments are more deconditioned, complex and suffering from long term conditions.

An ED, also known as an accident and emergency department (A&E), emergency room (ER), emergency ward (EW) or casualty department, is a medical treatment facility which specialises in emergency medicine, the acute care of patients who present without prior appointment; either by their own accord (self-presenting), by that of an ambulance or by referral from primary care. There are 3 types of ED:

- Type 1 department – major A&E, providing a consultant-led 24 hour service with full resuscitation facilities
- Type 2 department – single specialty A&E service (e.g. ophthalmology, dentistry)
- Type 3 department – other A&E/minor injury unit/walk-in centre, treating minor injuries and illnesses

Due to the unplanned nature of patient attendances, the ED must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.

The emergency departments of *most* hospitals operate 24 hours a day, although staffing levels may be varied in an attempt to reflect patient volume, nuance, financial viability/feasibility and/or local set up.

The ED at the Borders General Hospital (BGH) is a District General Hospital and provides care for the Borders population of 115,000. The BGH is situated centrally in Melrose in the Scottish Borders. The ED provides 24/7 care for patients across all age groups and receives 30,000 annual attendances.

Further demographic information can be found as Appendix 1.

Continued levels of high bed occupancy, coupled with notable increases across length of stay and occupied bed days (derived from delayed and non-delayed patients) has meant that patients have a longer than usual wait for a bed in the main inpatient (IP) footprint of the hospital. This increases the care and medical oversight required from key personnel across the ED including medical, nursing and allied health professional groups. Crucially, a junior skill mix in the overnight period brings a level of risk to the management of patients that is no longer tolerable.

Incidentally, once the ED becomes overwhelmed with patients unable to access IP beds, the department can quickly become overcrowded; the risks to patient safety and the adverse consequences on patient and staff experience of overcrowding in Emergency Departments are well known. It is difficult to maintain a clear view of the patients in the department when spaces are overcrowded, infection control and health and safety standards are more difficult to maintain, and the provision of expected care such as medication and personal care is compromised *(Forrero et al., 2010)*. Additionally, the privacy and dignity of patients cannot be maintained to the standards required. This point was one of the key findings from a recent unannounced safe delivery of care inspection carried out at a Scottish Territorial Board summarised that patients in the hospital were not treated with privacy and dignity.

A secondary point made during that same inspection summarised that the hospital was unable to ensure care and support was provided in a planned and safe way. These types of risks are typically derived from areas congested and overcrowded (although could apply to any care setting which experiences a surge in demand). Decongesting a busy ED is crucial to providing safe, effective patient centred care.

For the BGH, there is currently a risk on the risk register (4397 – graded very high) regarding long waits for beds greater than 4 hours and up to 40 hours, and due to levels of activity and demand the ED operating as a medical admission unit. These circumstances are suggestive of a system in crisis; one where the hospital is congested, with high occupancy and a mismatch between admissions and discharges.

The remaining action within the action plan associated with this risk is this review (this document).

There are local and well documented national challenges associated with recruitment and retention. NHS Borders has experienced these challenges and there has been a steady turnover of experienced ED nursing and medical workforce over the last 2 years. This review intends to provide options to drive forward a sustainable and resilient multi professional workforce. Furthermore, this timely

review is a response to the prolonged and consistent safety concerns derived from: clinical decision making in the overnight period, skill mix across the ED, and levels of clinical risk derived from both.

2.3 National/Local Context

The 4-hour emergency access standard ("the standard") is a whole system measure; to either admit or provide definitive treatment and discharge for 95% of unscheduled care patients within 4-hours requires a collaborative approach from all parts of the health and social care system to provide patient flow. Performance across Scotland was recorded at 62.9% for the week ending 19 March 2023. The performance for NHS Borders during the same period was 57.4%. This measure is a barometer of safety; it often provides good intelligence into the operations both at the front and back door of an Acute site and ensures patients whom require urgent care are being seen in a timely manner. Figure 1, (below) shows the BGH performance against Scotland vs. the target.

An ED requires an experienced senior decision maker underpinned by a suitably staffed multidisciplinary team to deliver care plans and ensure exit flow from the department twenty-four hours a day, and to ultimately deliver the required level of safety to meet the 4-hour emergency access standard (4EAS).

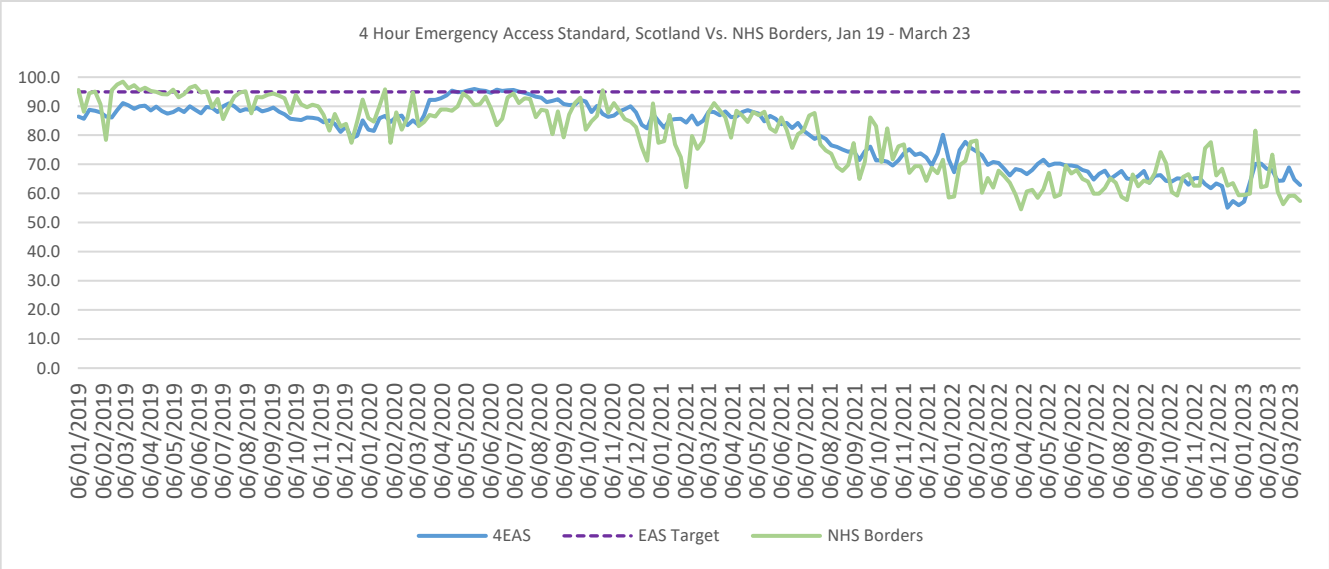

Figure 1 - 4 Hour Emergency Access Standard, Scotland vs. NHS Borders, Jan 19 – March 23

Table 1, shows the national deterioration in performance of the 4EAS across the 11 territorial Health Boards in Scotland. For NHS Borders the change in performance is not down to attendances but likely down to a combination of increased length of stay, acuity and delays. This combination inadvertently increases the level of pressure and risk across the ED derived from a lack of exit flow. Figure 2 shows the change in length of stay and the cumulative impact on 4EAS.

NHS Board	Population * *(data from ISD 2021/2022)*	Attendances March 2019 Per week	EAS %	Attendances March 2023 Per week	EAS %
Ayrshire & Arran	366,800	2169	85.4	1674	63.9
Dumfries & Galloway	148,790	805	92.2	855	78.9
Fife	371,910	1301	92.9	1454	68.4
Forth Valley	306,00	1252	93.6	1092	44.5
Grampian	584,550	1964	91.5	1750	57.5
Greater Glasgow & Clyde	1.2 million	7132	86.7	6252	69.8
Highland	235,540	1114	92.3	1142	77
Lanarkshire	319.020	4011	92.6	3812	58.3
Lothian	858,090	4566	86.6	4308	57.7
Tayside	416,080	1454	96.3	1553	78.9
Borders	**116,020**	**589**	**96.1**	**572**	**59.3**

Table 1 – Comparison of NHS Board, Population, Attendances and 4EAS

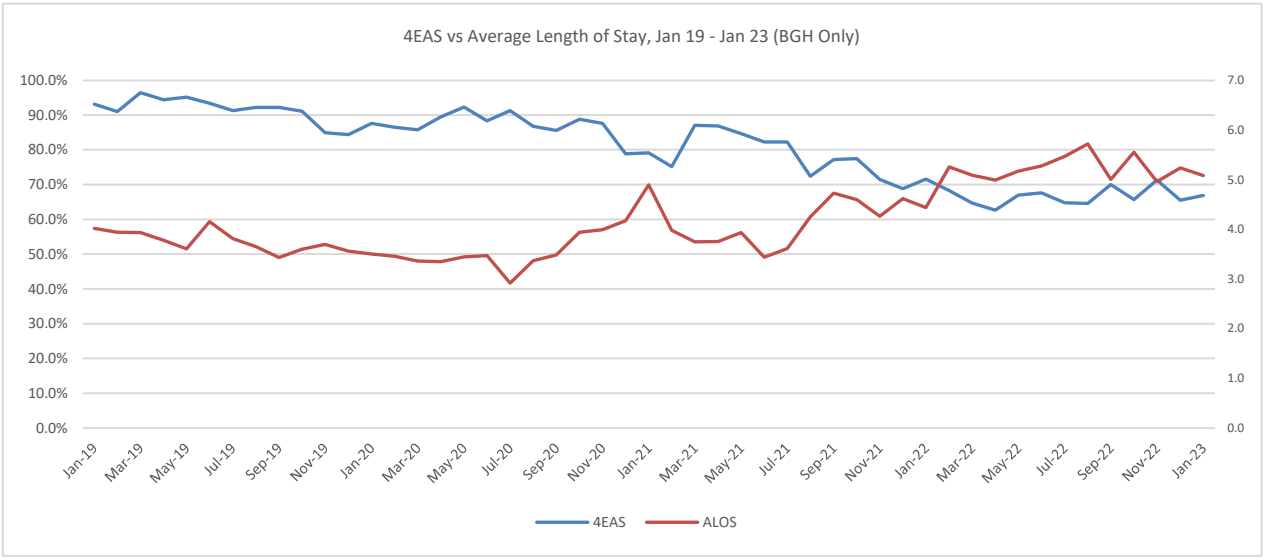

Figure 2 – 4EAS vs Average Length of Stay, Jan 19 – Jan 23

An ED needs to be underpinned by a robust workforce model to ensure timely offloading of ambulances, triage, access to a senior decision maker and care plan agreed. With specific reference to the ambulance performance, there are continued significant delays for ambulances at hospital sites across the country. The Scottish Ambulance Service (SAS) need to maintain the ability to respond to patients in the community. There is potential for clinical risk and harm occurring with patients affected by these delays, with potentially some level of harm being experienced in 85%[1] of patients where the handover is greater than 60 minutes, as well as potential moral injury to staff. The offloading of patients from ambulances into already overcrowded Emergency Departments and receiving areas also has the potential to cause harm.

[1] Principles for Safe Transfer to Hospital: Ensuring the Timeous Handover of Ambulance patients, April 2023, Scottish Government.

While there are wider system issues currently impacting performance and quality, addressing safe, patient centered care will require appraisal of the current workforce model to ensure it remains fit for purpose. The current data captured above demonstrates that the current ED workforce is not robust enough to manage the current pressures and requires an alternative model to mitigate the types of risk described above in section 2.2 and below in section 3.2. A full complement of quality and safety metrics can be found as Appendix 2.

3. Scope and Drivers for Change

3.1 Scope

The ED is located at the front of the BGH. It is neither a type 1 nor type 2 ED which means it operates somewhere between both types; as a functional emergency setting capable of supporting resuscitation and emergency treatment yet without 24-hour consultant cover and a medical model of "stabilise and transfer" for major trauma. The nearest major trauma centre to NHS Borders is in NHS Lothian and provided out of the Royal Infirmary of Edinburgh.

The ED is currently 35 years old and provides care for all age groups across predefined National triage categories. It manages emergency, major and minor injuries. It is led by a senior decision maker (consultant) and operates Mon – Fri 'in-hours' from 9.00 – 5.00pm. Out with these times and during the overnight period, the role of senior decision maker is provided by a single non consultant decision maker. ED was previously staffed by Ortho GPST for 26 weeks of the year. The remaining weeks were staffed via the ED roster. There is a significant risk attached to the management of the ED during the overnight period when the single handed GPST is the lone medical practitioner.

There are several adjacencies that support the delivery of safe patient centred care for the ED. These include proximity to: ambulance drop off points, diagnostics, ambulatory care, minor injuries and endoscopy.

The ED is comprised of a waiting area, reception, assessment/treatment and resuscitation spaces.

The department has a multidisciplinary workforce which is comprised of medical, nursing, admin and clerical staff. Table 2 and 3 below describe the main composition of the ED.

Professional Group	As is (WTE)
Medical	
Emergency Medicine Consultant	2.0
Spec Doctor/Junior/Middle Grade and Non-Consultant Medics	12.1
Nursing	
Registered Nurse	20.58
Health Care Support Worker	2.17
Emergency Nurse Practitioner	3.38
Admin and Clerical	
ED Clerkess	1.5

Table 2 - Emergency Department Current Workforce Arrangements

Service Function	Space
Resuscitation	3
Cubicles/Trolley Spaces	9
Minor Injuries	
Rooms	1
Welfare Spaces	
Staff Rest Area	1

Table 3 - ED Composition

This review considers an alternative workforce which mitigates the level of risk derived from clinical decision making in the overnight period, skill mix across the ED and levels of clinical risk derived from both.

By reducing the level of risk in the department the workforce will be suitably supported to meet the challenges of a district general hospital. The capacity, risk, proposals and drivers for change must be considered within this context to ensure feasibility and financial sustainability of the ED.

While the safety concerns regarding overcrowding, extended waits for IP beds and length of stay are factors for consideration, they are not considered primary drivers for this review. However, it must be acknowledged that when these pressures are persistent and prolonged, there is a need to consider surge capacity, and with it appropriate staffing. This is considered further in Section 6.5.

Function/Professional Group	
In Scope	Out of Scope
ED only	Welfare areas
Medical Cover (Senior Decision Maker, Junior and Middle Grades)	Department Infrastructure
Nursing Cover (Registered and Unregistered Nursing, incl. Emergency Nurse Practitioners)	Domestic Staff (Incl. Porters/Auxiliary Staff)
Reception	Surge Staffing
Admin and Clerical roles (ward Clerkess)	BECC/BUCC
	AHPs

Table 4 - Scope

3.2 Drivers for Change

The following section expands on the need for change as identified in the Strategic Context and describes the anticipated impact if nothing is done to address these needs and why action should be taken now through this proposal.

3.2.1 Additional Medical Cover (Overnight)

The overnight period reflects the most vulnerable period of the working day for the ED; there is a less experienced medical team available to support and manage complexity, there is reduced levels of wider medical support to provide expertise, and most significantly there is a lack of mutual aid for the single armed senior decision maker.

There is currently a risk on the risk register (1102 – graded Medium) regarding the lack of medical expertise in the overnight period. It reads that the ED is staffed by a single doctor between 12 midnight and 0800 each night. For 26 weeks of the year, this doctor is rostered to be an Orthopedic GPST who could only have two years medical experience and no experience in ED. This risk is graded as High.

The evening period also correlates directly with the time of the day the largest proportion of breaches are recorded thus demonstrating when the department is at its most unsafe. This is shown below in Figure 3, below. Ultimately, the rota could be reworked to match staffing with activity but this risks moving the breaches further into the day and spreading them rather than supporting to alleviate them.

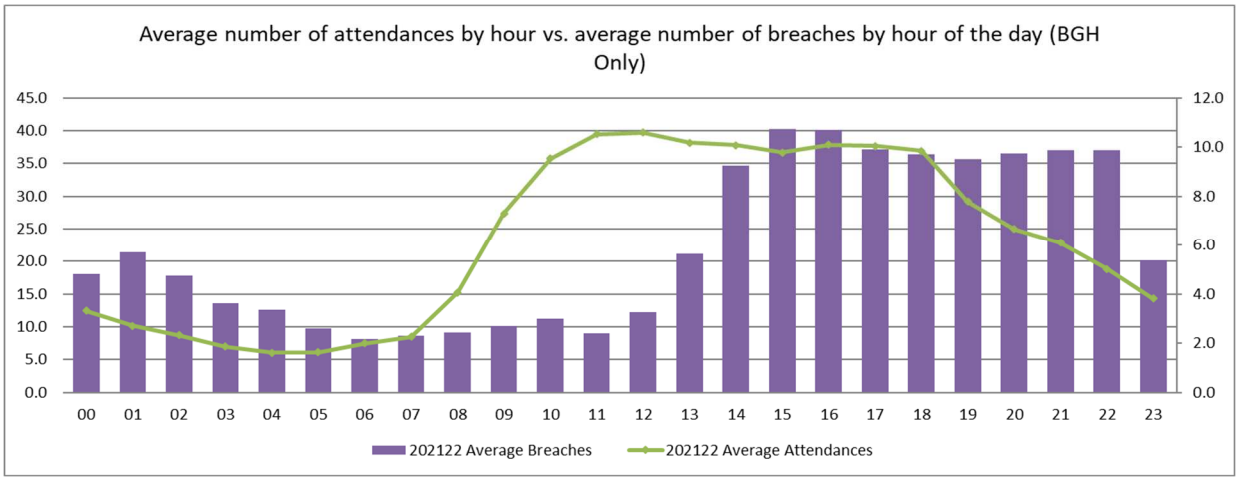

Figure 3 – Average number of attendances by hour vs. average number of breaches by hour of the day

3.2.2 Skill Mix

Long waits in the emergency department (ED) can adversely affect patients with longer inpatient stays, higher rates of mortality and higher costs of care. Nursing workforce numbers have not been formally appraised and considered since pre pandemic (prior to March 2020) and are therefore dated. As a result, this review considers optimal skill mix to address: current/emerging challenges, missed nursing opportunities and acuity. One study identified that a 10% increase in missed nursing care was associated with a 16% increase in the likelihood of 30-day inpatient mortality *(Amritzer, M.A., et al, 2021)*.

Reviewing skill mix is an approach to improve the overall effectiveness and efficiency of health (Sibbald, B., Shen, J. and McBride, A., 2004). The financial challenges across health and care both Nationally and locally present many challenges to the provision of healthcare. Therefore, this workforce review must consider optimal skill mix as a mechanism to not only address economic constraints, but also to improve care quality *(Dall'ora, C. et al, 2017)*. Ultimately, by reviewing the skill mix across the department, the investment made is not only in patient outcomes but also staff experience *(Robinson, K.S., Jagim, M.M. and Ray, C.E., 2005)*. An appropriately staffed ED manages activity, acuity, and risk to appropriate levels of tolerance and ensures the department remains as safe as possible.

3.2.3 Clinical Safety/Risk 2020-2023 (as of 11 May 2023)

An adverse event is defined as an event that could have caused (a near miss), or did result in, harm to people or groups of people or the organisation. Staff members are encouraged to record an adverse event which has the potential to cause harm; adverse events are defined as something that has or nearly (near miss) caused harm. Learning points come from the investigations of adverse events that have happened or are categorised within the adverse event management policy as unacceptable or preventable events

So far, this review has described that additional medical cover and skill mix are primary drivers for change. Of equal importance is the requirement to improve clinical safety and mitigate risk derived from those primary drivers. Table 5, below describes the volume of adverse events derived from those primary drivers over a period from 2021 – 2023. It is prudent to add that while every attempt is made to create time and space for reflection and reporting, it is known that during periods of extremis, opportunities to record an adverse event can be lost. Therefore, there is *some* evidence to suggest the numbers recorded below are under reported.

	2020	**2021**	**2022**	**2023** *(Up to 31/08/2023)*	**Total**
Medical staff reduced numbers	0	2	2	0	**4**
Skill mix unsafe	1	1	3	0	**5**
Nursing staff reduced numbers	1	11	27	0	**39**
Lack of staff to undertake patient observations/engagement	4	17	30	17	**68**
Total	6	31	62	17	116

Table 5 – Datix incidents reported relating to primary drivers for change

The volume of datix incidents raised demonstrate that clinical safety/risks should be considered a primary driver for change alongside 3.2.1 and 3.2.2, above.

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
Lack of medical senior decision maker (overnight)	Currently, during the out of hours period, there is a lack of support for the senior decision maker on shift. During instances of high medical need (such as resuscitation or cardiac arrest), department oversight can be lost which brings a significant level of risk to patients already in cubicles, or those waiting to be seen in the waiting room. Additionally, much needed professional support is lost. Risk 1102 on the risk register also refers to this concern and is graded as High.	A second overnight doctor was introduced to the department in on a temporary basis via the allocation of an additional post from NES in early 22/23 to provide professional support to the substantive senior decision maker. Surgical workload fluctuated below normal levels during the pandemic which provided an opportunity to provide a second overnight doctor (from Orthopedics). Now, as services remobilise fully to 100%, this Orthopedic capacity is no longer available to ED which in turn makes the rotas unsafe. This was not a substantive arrangement and was provided from the current Orthopedic rota which has increased pressure on Orthopedics. To provide resilient and robust overnight senior medical support on an ongoing basis, the second overnight doctor requires to be made substantive, and part of a permanent ED workforce.
Poor skill mix across the department	The real-time nursing tool was last run pre-covid. The lack of revision into modern nurse ratios, alternative roles and optimal skill mix has meant that that the workforce is outdated. Additionally, gaps in skill mix/establishment contribute to a poorer staff experience across this high risk clinical area.	Nursing numbers are projected to stabilise throughout 23/24 but most prominently by October 2023. This gives an ideal opportunity to review and consider the optimal skill mix, as defined by the real time staffing tool ahead of Winter 2023.
Levels of clinical risk	The volume of adverse events shown in table 5 demonstrate that the risks are materialising from a lack of resilience to the second overnight doctor in ED, coupled with poor Nursing skill mix is not	There are two live Significant Adverse Event reviews in progress which further demonstrate the level of risk derived from the primary drivers is no longer acceptable. To support services remobilise fully to 100%, the ED rotas will in turn become unsafe. NHS Borders can no longer tolerate the level of clinical harm, adverse staff and patient

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
	acceptable. Increasing acuity, and long waits for IP beds (as a result of length of stay across both delayed and non-delayed patients) has exacerbated the likelihood (and consequence) of further adverse clinical events, and impacts of moral harm/staff wellbeing.	experience and harm caused by sub-optimal staffing arrangements within the most clinically vulnerable area of the hospital. Risk 4397 on the risk register (graded very high) also describes how near miss/adverse events contributes to poorer patient/staff experience. The remaining action within the action plan for this risk is this review.

Table 6 – Drivers for Change

3.3 Strategic Risks

The table below highlights key strategic risks that may undermine the mitigations of the risks described above. These are described thematically and potential safeguards and actions in place to prevent these

Theme	Risk	Safeguard(s)
Funding	NHS Borders is currently one of a number of Board on Scottish Government financial escalation. Therefore, any decision to invest in services must be a risk backed decision and must provide best value not only for the service but for NHSB as a whole. There is no additional financial support available via SG due to the overall financial deficit in the health portfolio which has been estimated as a deficit in the region of £	The ED team undertaking this review have worked to ensure that this proposal reflects best value. While National standards and policies for a safe/functioning ED have been considered (see Appendix 3), they have been modified and considered against the risks to ensure financial sustainability for a district general hospital. The Deputy Director of Finance has reviewed this proposal with clinical staff to ensure that they are the most cost effective options in order to mitigate the articulated clinical risks, and risks to staff wellbeing/moral injury.
Service Continuity	Disruption to the service delivery following recruitment needs	A second ED doctor has been supported (non-recurrently) from the Orthopedic rota to support the department in the out-of-hours period. Bank/Agency shifts have also been considered to manage any consistent Nursing gaps – current arrangements will continue to be supported while an implementation plan is developed, should the proposed option be agreed. Off-Framework agency nursing will not be supported from June 1st.
Performance	Workforce model does not match future performance requirements or need for additionality (a failure to sustain the required recommended improvements to length of stay of delayed and non-delayed patients)	The focus of this review is Core-ED as defined in Section 3.1. Any surge areas should be considered separately. Any non-recurring funding for surge areas allocated to address system wide pressures will be risk assessed to define how this can be safely managed, and be considered separately.

Theme	Risk	Safeguard(s)
		Improvements to length of stay et al are being managed through the Urgent and Unscheduled Care Programme – see Section 6.5
Staff/Patient Experience	Continued levels of dissatisfaction derived from risks and safety exacerbate feelings of anxiety, stress and burnout. Additionally, they impact in the ability to attract, recruit and retain staff.	The ED Management Team are focused on ensuring staff are supported. ED huddles have been established daily at 9am to debrief from the last 24 hours and pick up areas of focus, support and reflection. Furthermore, a recently established Clinical Management Team (CMT) from the front door has representation from the Deputy General Manager, Clinical Nurse Manager and Clinical Director. Area of focus for this CMT include learning from ED walk rounds, addressing areas of concern (both from a performance and staff governance perspective) and collective and joint ownership of challenges. Within this CMT adverse events/risks and complaints are reviewed for learning opportunities.

Table 7 – Strategic Risks

4. Standards, Dependencies and Constraints

4.1 Standards

The size of an ED is an important determinant as to how it should be staffed and how standards and guidelines should be applied. Size coupled with the volume of annual attendances often dictate the specific workforce model that should be applied. However, it is important to consider local context/viability into any proposed model irrespective of the underpinning guidelines and minimum standards. Local Health Boards are accountable to ensure their workforce models are safe, effective and enable patient centered care. Insufficient staffing contributes to longer waits, crowding, compromises to safe practice, reduction in the quality of care and poor experience for patients and staff.

Remote and Rural EDs typically manage less than 60,000 attendances per annum (for NHS Borders it is even less at 30,000). However, workforce planning should consider the whole emergency pathway and should take into account variation in demand and not be purely based on average demand. Basing the workforce model on average attendances, and failing to consider the rurality/geography of the health board has the potential to create delays to patient care during periods of peak demand.

An appropriate ED workforce is a crucial factor for providing safe, effective, high quality emergency care in a timely manner. This requires a balanced team of nurses, doctors, allied health professionals, and support staff with appropriate knowledge and skills.

Medical

The RCEM Workforce Recommendations (2018) has defined a ratio of 1 WTE EM consultant to between 3,600-4,000 new attendees. This is dependent on complexity of workload and associated clinical services for which the ED is responsible. The RCEM also recommends staffing levels based on the size banding of the ED, for example, sites with less than 60,000 attendees are recommended to hold 6 WTE Consultants in post (for 12-16 hours per day). This compares to 10 WTE Consultants in larger EDs and Major Trauma Centers. For a population size of c.116k, NHS Borders has 2 consultants at a rate of 1 consultant per 58k citizens. A comparison of other Boards is shown on Table 20.

While the recommendations demonstrate that the BGH ED falls far short of this standard, it is important to understand financial/clinical context, viability and skill mix. Additionally, the *pattern* of attendances need to be considered to ensure adequate senior decision making oversight is scheduled where it is needed.

Nursing

The *standard* for an ED is an Emergency Nurse workforce broken down as 80% registered nurses to 20% unregistered. The skill mix across an ED ensures sufficient emergency/senior charge nurses to deliver safe clinical care, providing supervision of registered nurses, student nurses and clinical support workers. Both Nursing and Medical standards required are referenced in risk 4397.

Further detail on the required standards and breakdown of skill set can be found as appendix 3.

4.2 Dependencies

The key dependencies are considered:

1. Nursing Workforce
    a. Nursing has come under significant pressure over the last 24 months, with the BGH carrying a vacancy leave of on average 30-40 WTE registered nurses. The deficit in nursing staff is a national problem as the number of registered nurse training place does not meet the need of the service and while being addressed will take a number of years to resolve. This deficit in nursing staff was being managed by the use of bank and agency. While these staff allow area to run safely they do not give consistency or allow for the development of team dynamics. During 2022/23 NHS Borders began recruitment of international nurses and by September 2023 it is estimated that establishments will be fully filled. This will allow stability within teams and allow for development of roles leading to improvement in satisfaction and ongoing sustainability in nursing roles.

2. BUCC/BECS
    a. There is currently an options appraisal process underway for the Borders Emergency Care Service (BECS) which is located in the Day Hospital. The role of BECS is to provide out of hours urgent primary care to patients who would be seen by a GP during the daytime and operates from 6pm until 8am on weekdays – BECS provides 24 hours cover at weekends. The care provided is made up from a combination of home visits, patients attending and providing telephone advice.
    b. The BECS/ED function previously shared reception facilities prior to the pandemic. The receptions were only split to protect immunocompromised patients from being infected during the peak of the pandemic. An option to revert back to a pre pandemic setup would bring efficiencies, cross cover, mutual aid and access to

sustainable workforce. It may also make the proposed options more financially viable.

c. The role of reception in ED and 'coordinator' in BECS are different roles and require access to different systems; however, both roles have been evaluated at Band 2 under AFC and therefore it is reasonable for a single member of staff to be trained to manage both BECS/ED admin activity in the out of hours period (10.30pm – 8am). There are currently **no** substantive staff aligned to the ED reception in the out of hours period (with substantive staff instead aligned to BECS). This means that during periods of no cover the requirement to operate reception duties falls to a clinical member of staff. This has occurred 5 times during the month of May 2023.
d. It is recommended that further engagement is undertaken to revert back to a pre pandemic set up for both functions with the nuance of 2 reception staff located in ED until 10.30pm.

4.3 Constraints

The key constraints to be considered are:

- Finance position across local/National context - NHS Border is currently receiving tailored support from Scottish Government (SG) as a direct result of the financial and recovery plan for 2023/24 not being considered robust enough. Over the past 2 years, NHS Borders has required brokerage from SG of approximately £20m to ensure that the Board has achieved a break even position. In 23/24, the Board is reporting a financial deficit in the region of £20m-£30m without a robust plan to address and reduce. The financial outlook for NHS Scotland as a whole is currently being reported as deficit in the region of £1b. Therefore, securing brokerage to achieve the statutory target of breakeven is becoming more problematic. At a local level, NHS Borders must demonstrate a robust plan to reduce costs and therefore any new investment will only be possible where the Board is facing an ongoing risk (graded as high or above) which can be clearly be mitigated by investment. Any new investment must be minimised to ensure that only immediate risks are mitigated as investments will only mean a greater saving target to be met by other services.
- Recruitment timescales - The NHS in Scotland are facing recruitment challenges in most professions but in particular across nursing and medical staffing. While international recruitment of nursing staff will fill current vacancies, any increases to funded establishments may prove problematic to recruit to and will inevitably lead to pressure on staffing as recruitment may take 6 months to a year. Medical staffing recruitment is also an areas of concern across the whole of Scotland and NHS Borders has had to employ agency locums for extended periods of time (up to a year) to cover vacant posts. Therefore, any new workforce model should consider these difficulties and timescales.
- Interaction and co-dependencies between existing services/specialties (incl. surgery) - Currently a proportion of the staffing in the Emergency Department is provided from the orthopedic medical cohort. This often proves challenging when ensuring that rotas are aligned and when sickness absence occurs there is often conflict between the two area as to which rota takes precedent. These factors lead to this arrangement being problematic.

5. Development of Options

5.1 Engagement with Stakeholders

The table below summarises the stakeholders impacted by this proposal and the details of the engagement that has taken place with them to date and notes their support for this proposal:

Stakeholder	Engagement that has taken place	Confirmed support for the proposal
Medical	Discussions with key stakeholders from the Emergency Department Medical team have taken place, supported by the Clinical Lead for Emergency Medicine to understand their requirements and feed into any modelling to date.	An MDT led approach has been leading this work. The 'drivers for change' was based on the fundamental problems associated with single armed services, sustainability and risk derived from patient safety information (adverse event) collected over a 24-month period. Further work has been led by Diane Keddie – Deputy General Manager (Unscheduled Care) with stakeholders/staff groups in the Emergency Department regarding where the opportunities for improvement lay. Wider stakeholder engagement has included: Nursing, Medical, Finance, Management, Staff Side (Partnership).
Nursing	Discussions with key stakeholders from the Emergency Department Medical team have taken place, supported by the Clinical Nurse Manager and Senior Charge Nurse for Emergency Medicine to understand their requirements and feed into any modelling to date. The Clinical Nurse Manager for ED changed twice during the period in which this review was developed due to retiral and vacancies.	
Finance	The Deputy Director of Finance has been involved from the very outset of this work helping shape financial viability, the case for change and options for sustainability.	Each option has been reviewed with clinical staff to ensure that they are the most cost effective option in order to mitigate the articulated risks
Management	The Senior Leadership Team, alongside Executive team have been engaged in this review with it first being commissioned in 2022. It is a key deliverable in achieving the safety standards required of the ED at the BGH. The Associate Medical Director, General Manager, Associate Director of Nursing and wider team have been sighted on	The Management team is very focused on securing support in the overnight period that mitigates the risks derived from single armed medical models and a lack of skill mix. The joint directive that any future medical model should be financially sustainable, clinically viable and achievable have been considered when developing the options for appraisal, and when considering the advantages/disadvantages and risks associated with each model. To that

	developments throughout the process.	end, the preferred option represents best value and mitigates the risks identified.

Table 8 – Engagement with Stakeholders

5.2 Approach

Section 3.1 (above) describes the scope of this workforce review. In summary, the following personnel are considered in scope:

- Medical
- Nursing
- Clerical

In developing a long list of options for review and reference, two approaches where considered:

1. Workload tool – The workload tool is a Nationally approved approach to cross reference departmental staffing requirements. The workload tool was employed during the 10 – 23 October 2022. The tool takes into consideration the current pressures across the area in scope. In ED this included: scheduled nursing and medical personnel, patients in department, and patients waiting admission.

2. Professional judgement – this approach took the findings of the workload tool analysis and brought key multi-disciplinary/professional groups together to consider workforce models against recruitment viability, financial viability and risk context.

The findings from both the workload and professional judgement tool are summarised below with full workings shown as appendix 4:

	Workload Tool (WTE)	Breakdown	Professional Judgement (WTE)	Breakdown	Variance
Medical	18.8	6 consultants 12.8 non-consultants[2]	18	5 consultants 13 non-consultants	0.8
Nursing	37.5	31.9 Registered Nurses inc ENP and 5.6 Health care Support Worker	41.67	33.9 Registered Nurse inc ENP and 7.77 Health Care Support Worker	(4.17)

Table 9 – Workload Tool and Professional Judgement

The workload tool was run during a period when surge capacity in the Emergency Department was open on a fairly consistent basis. As noted previously, this surge capacity known as Blue ED will be dealt with separately.

Using professional judgement of senior nursing staff, the workforce tool has been adjusted to reflect that this additional workload will only be required on a non-recurring basis (should the system be reset to pre pandemic ways of working/levels of occupancy and delays). Further reference to professional judgement in this paper will be this adjusted version as shown by Table 10, below.

[2] Refers to non-consultant medic – junior, middle grade or spec doctor

	Workload Tool (WTE)	Breakdown	Professional Judgement (WTE)	Breakdown	Variance
Medical	18.8	6 consultants 12.8 non-consultants	18	5 consultants 13 non-consultants	0.8
Nursing	32.31	26.71 Registered Nurses incl. ENP and 5.6 Health care Support Worker	36.48	28.71 Registered Nurse in ENP and 7.77 Health Care Support Worker	(4.17)

Table 10 – Workload Tool and Professional Judgement (Core ED only)

5.3 Long List of Options

Given the complexities in laying out options for an ED, and the interdependencies and reliance of professional bodies to support each other, the workforce options have been split by professional body and options considered against appropriate advantages/disadvantages and key risks.

5.3.1 Medical

Options 1-5	Advantages/Disadvantages	Key Risks	Cost £000s
<u>Option 1 – Baseline</u> Status Quo: EM consultants (2 WTE) Monday – Friday (supported by current in hours daytime rota – see appendix 5) and 1 doctor on night shift	**1.** No further financial pressure on NHS Borders	**1.** There is a risk that a single handed senior decision maker in the overnight period is an unsustainable model to manage short notice sick leave, or periods of planned/unplanned leave; **2.** There is a risk that a single handed senior decision maker in the overnight period will face a disproportionate amount of pressure compared to in-hours services due to a lack of peer support leading to a poorer staff experience; **3.** There is a risk that a single handed senior decision maker will be unable to provide an equitable standard of service to patients during periods of high clinical activity which will cause a poorer patient experience. **4.** There is a risk that a single handed senior decision maker in the overnight period will unable to provide the required level of support to junior staff due to the demands placed on them to support senior decision making.	£1,720

		5. There is a risk that a single handed senior decision maker in the overnight will incur delays to first assessment and increase delays to care during periods of high clinical activity.	
<u>Option 2 – Do Minimum</u> EM consultants (2 WTE) Monday- Friday (supported by current in hours daytime rota) with 2 Doctors on night duty	**1.** The addition of a second medical practitioner in the overnight period provides a level of resilience in the case of short notice unplanned leave. **2.** The addition of a second senior decision maker in the overnight period will reduce delays to first assessment by increasing the capacity of the medical team **3.** The addition of a second senior decision maker increases the potential for learning, peer support and mutual aid during periods of high clinical activity **4.** The second senior decision maker model has been tested already through the orthopedic rota and has proven to support 1-3 above.	**1.** There is a risk that the opportunity to appoint a suitably skilled medical workforce by the availability in the labour market. **2.** There is a risk that this option is not financially viable.	£2,221
<u>Option 3 – Do Minimum Plus</u> EM consultant (3 WTE) Monday – Friday (supported by current in hours daytime rota) and 2 Doctors on night duty	**1.** A third consultant increases the senior decision making presence for longer in the day and provides robust access to care **2.** A third consultant provides succession planning for the department	**1.** There is a risk that the opportunity to appoint a third consultant level medic would be disrupted by the availability in the labour market (previous attempts have been unsuccessful); and **2.** There is a risk that the model described provides minimal weekend cover when the acute site is	£2,363

	3. A third consultant increases the ability to provide upskilling, training and future service planning. **4.** A third consultant is likely to improve the likelihood of retention given an equitable split of workload **5.** A third consultant spreads senior decision making cover across the day period. **6.** A third consultant will increase supervision capacity for trainees which in turn improves staff experience and retention opportunities	more vulnerable with less clinical/non-clinical support available to the ED. **3.** There is a risk that this option has a greater financial risk that the do minimum option.	
<u>Option 4 – Professional Judgement</u> EM Consultant led service 7 days (5 WTE) underpinned by 13.8 non- consultant medical staff.	**1.** A fully operational consultant led model would reduce the level of clinical risk derived from lack of senior decision making; **2.** A fully operational consultant led model provides long term resilience and retention of senior decision making capacity; **3.** A fully operational consultant led model provides an equitable spread of senior decision making across a 7 day period.	**1.** There is a risk that in order to support a 2 doctor overnight service, this option would require a reduction in non-consultant daytime medical staffing; **2.** There is a risk that the proportion of in hours staff would require to be decreased to support the overnight period; **3.** There is a risk that the opportunity to recruit additional consultants would be disrupted by the availability in the labour market (previous attempts have been unsuccessful); **4.** There is a risk that this option is not appropriate for the level of activity, rurality or demand on the ED; and	£2,489

		5. There is a risk that this option is not financially viable.	
<u>Option 5 – Workload Tool</u> EM Consultant led service 7 days (6 WTE) underpinned by 12.8 non- consultant medical staff	**1.** A fully operational consultant led model would reduce the level of clinical risk derived from lack of senior decision making; **2.** A fully operational consultant led model provides long term resilience and retention of senior decision making capacity; **3.** A fully operational consultant led model provides an equitable spread of senior decision making across a 7 day period	**1.** There is a risk that the proportion of in hours staff would require to be decreased to support the overnight period. **2.** There is a risk that the opportunity to recruit additional consultants would be disrupted by the availability in the labour market (previous attempts have been unsuccessful); **3.** There is a risk that this option is not appropriate for the level of activity, rurality or demand on the ED; **4.** There is a risk that in order to support a 2 doctor overnight service, this would require a greater reduction in non-consultant daytime medical staffing; and **5.** There is a risk that this option is not financially viable.	£2,567

Table 11 – Long List Medical

5.3.2 Nursing

Options 1-3	Advantages/Disadvantages	Risks	Cost £000s

<u>Option 1 – Status Quo</u>
 	
• 1 wte Senior Charge Nurse(SCN);
• Days (in hours)
  o 4.6 RGN,
  o 1 HCSW
• Nights (overnight)
  o 3 RGNs
	1. No further financial pressure on NHS Borders	**1.** There is a risk that the current RGN models leaves little resilience in the case of short notice sickness or unplanned leave;
		
		2. There is a risk that Nursing teams in the out of hour period face a disproportionate amount of pressure compared to in-hours services due to a lack of peer support and skill mix; and
		
		3. There is a risk that the current model fails to provide a robust and resilient workforce capable of maintaining a positive staff and patient experience.
			£1,275

<u>Option 2 – Professional Judgement</u>
• Days (in-hours)
  o 1 wte SCN;
  o 5 RGN covering 730am-8pm; and
  o 2 HCSW.
• Night (out-of-hours)
• 4 RGN
• 1 HCSW nights
	1. Full compliance with recommended RCEM Emergency workforce guidelines;
	
	2. A richer multidisciplinary team will be able to provide increased mutual aid, support and training;
	
	3. This option makes use of a richer skill mix allowing staff to work at the top of their band; and
	
	4. This option provides a more robust management of patients over a 24 hour period which in turn will reduce delays to care.
		1. There is a risk that recruiting to this model would be challenges by the availability of a workforce with the correct skill set;
		
		2. There is a risk of over establishment out with times of peak demand; and
		
		3. There is a risk that this option may not be financial viable.
			£1,750

Option 3 – Workload Tool
• Days (in-hours)
  ○ 1 WTE SCN
  ○ 5.5 RGN
  ○ 1 HCSW
• Night (out-of-hours)
  ○ 4 RGN night duty;
  ○ 1 HCSW nights
	1. Full compliance with recommended RCEM Emergency workforce guidelines;
	
	2. A richer multidisciplinary team will be able to provide increased mutual aid, support and training;
	
	3. This option makes use of a richer skill mix allowing staff to work at the top of their band.
		1. There is a risk that recruiting to this model would be challenges by the availability of a workforce with the correct skill set;
		
		2. There is a risk of over establishment out with times of peak demand; and
		
		3. There is a risk that this option may not be financial viable.
			£1,720

Table 12 – Long List Nursing

5.3.3 ENP

Options 1-2	Advantages/Disadvantages	Risks	Cost £000s
Option 1 status Quo – ENP lead Minor Injuries 2 x 7.5hr shift 7 days per week working with nursing and medical team	**1.** This option provides relative cover during the in hours period to reduce the burden on specialized medical input for minor injuries. **2.** This option provides capacity to manage minor injuries led activity away from the ED during core periods if scheduled to match patch presentations. **3.** There is insufficient capacity to manage activity currently derived from NHS 24 pathway	**1.** There is a risk that that current team set up has little/no resilience to cover short term sickness/unplanned leave which puts additional pressure on Emergency Department; **2.** There is a risk that the current Minor Injuries Services cannot manage activity out with core times which would increase pressure on senior medical clinical time; **3.** There is a risk that this ENP provision is insufficient to meet the demand derived from NHS 24 which has been increasing since the pandemic ended; and **4.** There is a risk that the current workforce provides no further opportunity to develop	£212

		pathways out of EDs (medical/surgical hot clinics, frailty pathways) due to a demand on ENP capacity.	
Option 2 – ENP led Minor Injuries (Enhanced Provision) Cover from ENP 9am-9.30pm and additional ENP 8hrs per day 7 days per week	**1.** This option provides relative cover during the in hours period to reduce the burden on specialized medical input for minor injuries. **2.** This option will support a more robust 'pull' model from the ED; **3.** This option will support capacity to deliver the National agenda around increasing the volume of scheduled appointments for NHS 24 and self-presenting patients;	**1.** There is a risk that recruiting to this model would be challenges by the availability of a workforce with the correct skill set; **2.** There is a risk that the benefits of this option may not be realized under training posts are fully qualified leading to a period of increased supervision from existing workforce; **3.** There is a risk that this option may not be financial viable	£275

Table 13 – Long List ENP

5.3.4 Clerical[3]

Options 1-2	Advantages/Disadvantages	Risks	Cost £000s
Option 1 Status Quo – ED clerk 1.5 WTE	**1.** The substantive appointment of the ED clerk will provide adequate capacity to support essential ED function: ordering transport, managing SSTS, managing routine enquiries from internal and external sources.	**1.** There is a risk that a failure to support substantive appointment of clerk support risks clinical teams undertaking non clinical tasks.	£54

[3] Please see section 4.2, dependencies, point 2

Option 2 - ED clerk 9am-9.30pm 2.59 WTE	**1.** The substantive appointment of the ED clerk will provide adequate capacity to support essential ED function: ordering transport, managing SSTS, managing routine enquiries from internal and external sources. **2.** Patients can attend throughout the 24 hour period and it is crucial that adequate non clinical support is matched to presentation and work profile.	**1.** There is a risk that a failure to support substantive appointment of clerk support risks clinical teams undertaking non clinical tasks.	£93

Table 14 – Long List Admin and Clerical

5.3.5 Summary

Do options meet the drivers for change as detailed					
Medical					
	Option 1 – Status Quo	Option 2 – Do Minimum	Option 3 – Do Minimum Plus	Option 4 – Professional Judgement	Option 5 – Workload Tool
Lack of medical senior decision maker (overnight)	No	Partial	Yes	Fully	Fully
Poor skill mix across the department	No	Partial	Yes	Fully	Fully
Levels of clinical risk	No	Partial	Yes	Yes	Fully
Are indicative costs likely to be affordable					
Affordability	Yes	**No**	**No**	No	No
Preferred/Possible/Rejected	Rejected	**Possible**	**Preferred**	Rejected	Rejected

Table 15 – Summary of Medical Options vs Drivers for Change

Do options meet the drivers for change as detailed			
Nursing			
	Option 1 – Status Quo	Option 2 – Professional Judgement	Option 3 – Workload Tool
Lack of medical senior decision maker (overnight)	N/A	N/A	N/A
Poor skill mix across the department	No	Partial	Fully

Levels of clinical risk	No	Partial	Partial
Are indicative costs likely to be affordable			
Affordability	Yes	No	No
Preferred/Possible/Rejected	Rejected	**Rejected**	**Preferred**

Table 16 – Summary of Nursing Options vs Drivers for Change

Do options meet the drivers for change as detailed		
ENP		
	Option 1 – Status Quo Minor Injuries	Option 2 – ENP led Minor Injuries (Enhanced Provision)
Lack of medical senior decision maker (overnight)	N/A	N/A
Poor skill mix across the department	Partial	Partial
Levels of clinical risk	Partial	Partial
Are indicative costs likely to be affordable		
Affordability	**Yes**	**No**
Preferred/Possible/Rejected	Rejected	**Preferred**

Table 17 - Summary of ENP Options vs Drivers for Change

Do options meet the drivers for change as detailed		
Clerical		
	Option 1 – ED clerk 1.5 WTE	Option 2 – ED Clerk 2.59 WTE
Lack of medical senior decision maker (overnight)	N/A	N/A
Poor skill mix across the department	Partial	Partial
Levels of clinical risk	Partial	Partial
Are indicative costs likely to be affordable		
Affordability	**Yes**	**No**
Preferred/Possible/Rejected	Rejected	**Preferred**

Table 18 – Summary of Medical Options vs Drivers for Change

5.4 Short-Listed Options

As summarized in the tables above, the following options have not been recommended to be taken forward for further assessment as detailed below in sections 5.4.1 – 5.4.4

5.4.1 Medical

- **Option 1: Status Quo**. This option does not mitigate any of the clinical risks described in section 3.2. Furthermore, the option does not provide the required level of senior decision making oversight required to ensure safe patient centered care
- **Option 4**: **Professional Judgement.** Despite meeting the change drivers, there is a risk that in supporting a 2 doctor overnight service, this would require a reduction in non-consultant daytime medical staffing, and in doing so increase overnight safety at the expense of in hours. There is also a high risk of failing to recruit for the required number of medical consultants. Finally, the option is financially inviable, even when cross referenced against clinical risk as described in section 3.2.3.
- **Option 5: Workload Tool.** This option fully meets the change drivers but is financially prohibitive and inappropriate for the level of activity and rurality of the BGH. As with option 4 above, there is a risk that in supporting a 2 doctor overnight service, this would require a reduction in non-consultant daytime medical staffing, and in doing so increase overnight safety at the expense of in hours.

5.4.2 Nursing

- **Option 1: Status Quo –** This option does not mitigate any of the clinical risks described in section 3.2 and has no associated advantages.
- **Option 3: Professional Judgement -** Despite meeting the change drivers, it was felt the workload tool better met the needs of the service and was financially more expensive than the workload tool even when cross referenced against clinical risk as described in section 3.2.3.
- **Option 1: Status Quo –** This option does not mitigate any of the clinical risks described in section 3.2 and has no associated advantages**.**

5.4.3 ENP

- **Option 1 – Status Quo Minor Injuries –** This option reduces Minor Injuries provision to pre pandemic set up where there was less need for "pull" from the ED department, patients could be considered less acute and deconditioned. The need to decongest the department is increasingly critical and during periods of extremis, the ENP can support main ED and provide much needed support to Nursing and Medical teams. That ability is lost with Option 1 which provides basic coverage.

5.4.4 Clerical

- **Option 1- Status Quo** – Currently clerkess cover is only provided between 9am and 5pm and as demonstrated previously in this paper the presentation of patients has shifted to later in the day. Therefore, clerical support is required at this time.

  Due to the fact there is only one clerical staff member on duty currently it is impossible to shift their working pattern which detracts from the ability to flex and respond to new and emerging periods of pressure. Therefore, there is a significant risk that clinical staff will have to pick up these

duties during an already busy period. The impact of this risk is significant; clerk duties are essential to ensure that patients are captured correctly for patient safety and governance. This defaulting to clinical staff takes essential care givers away from direct clinical care.

5.4.5 Preferred way forward

From the *initial* assessment above the following short-listed options have been identified

Option	Description
Medical	
Option 2 – Do Minimum	EM consultants (2 WTE) Monday- Friday (supported by current in hours daytime rota) with 2 Doctors on night duty
Option 3 – Do Minimum Plus	EM consultant (3 WTE) Monday – Friday (supported by current in hours daytime rota) and 2 Doctors on night duty
Nursing	
Option 3 – Workload Tool	Days (in-hours) 1 WTE SCN, 5.5 RGN, 1 HCSW Night (out-of-hours) 4 RGN night duty, 1 HCSW nights)
ENP	
Option 2	Cover from ENP 9am-9.30pm and additional ENP 8hrs per day 7 days per week
Clerical	
Option 2	ED clerkess 9am to 9.30pm 7 days per week

Table 19 – Preferred Options

5.4.6 Surge

The ED at the BGH is currently experiencing a prolonged and persistent period of pressure derived from a number of complex issues: higher levels of acuity, increased length of stay, the volume of patients boarded to inpatient beds out with specialty and delayed discharges. As described in section 2.3 (above), the 4-hour emergency access standard acts as a barometer for system wide pressure and safety. Figure 2 (above) and 4 (below), demonstrate the impact of length of stay (of both delayed and non-delayed patients) and delayed discharges on this crucial safety metric.

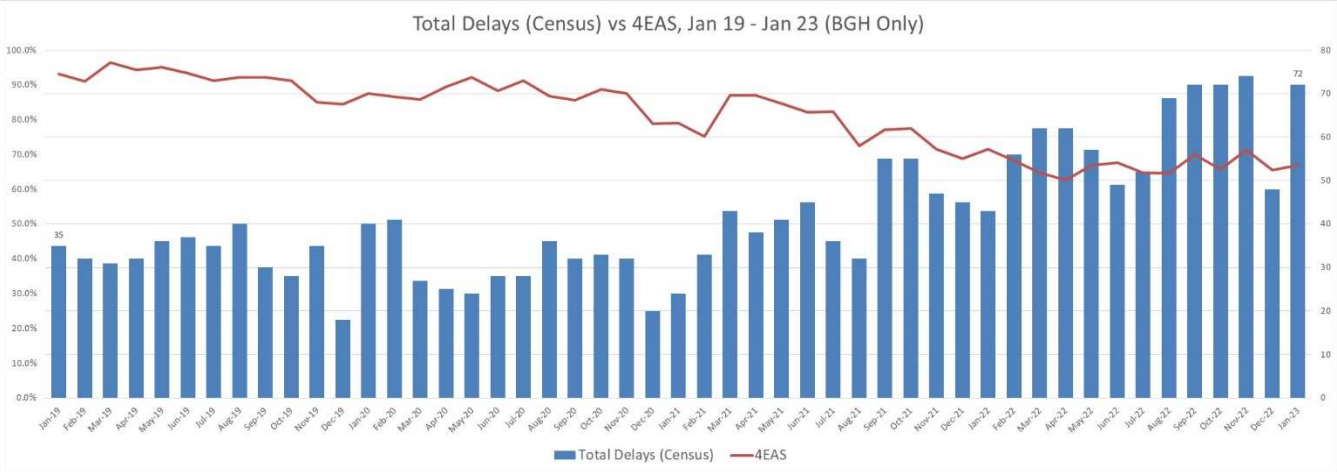

Figure 4 – Total Delays (Census) vs 4EAS, Jan 19 – Jan 23

In addressing these system wide pressures associated with long waits, delays and overcrowding, the accepted form of acute based de-escalation has traditionally revolved around opening additional surge capacity. The opening of surge capacity to address front/back-end flow limitations carries several supplementary key risks; (1) an inability to staff additional areas to core nursing establishment, (2) an inability to provide adequate medical cover to manage surge areas, (3) increased probability of patients occupying beds out with specialty (known as boarding) and (4) an increased financial spend to manage 1 and 2 above. For the ED, the response to managing overcrowding (or delays to downstream inpatient beds) is managed by opening its own surge capacity in "Blue ED" (previously Ortho outpatients). This is an area that is surged into and is comprised of 11 assessment spaces (Rooms 14 – 18, and Room 12 with 3 assessment spaces).

There are undoubtedly opportunities to improve patient flow across the BGH. A focused approach on reducing the length of stay will reduce the number of beds required and create capacity for patients awaiting IP care. Length of stay (in both delayed and non-delayed patient activity) is the focus of efforts for joint working between acute, health and social care partnership and wider community teams. These efforts are underway and relate to a plethora of improvement activity that is monitored and supported through the auspices of the Urgent and Unscheduled Care Programme Board. This improvement work requires time to provide the benefits needed to effectively reduce system wide pressures which often culminate in longer waits in the ED, and they requirement to open surge capacity.

During the winter period, the emergency department faces intensified pressures. Seasonal illnesses like flu, respiratory and norovirus infections and colder temperatures can exacerbate chronic health conditions. Furthermore, within the workforce there are higher-than-average levels of sickness absence. The collective impact of these challenges amplifies the workload for emergency staff, necessitating seamless coordination, rapid decision-making, and optimal resource allocation to ensure quality care amidst heightened demand. Once coupled with the additional surge capacity already opened throughout the Acute site, this makes for a congested system and necessitates the use of Blue ED.

The Winter Plan 23/24 is primarily concerned surge and occupancy planning; permanently stepping down surge capacity by offsetting acute bed capacity with community capacity. This winter plan would allow the surge in ED to close around December which would mean that the cost of surge April to December 23 would be £365k There remains significant risk associated with the winter plan as the stepping down of surge capacity across acute services is predicated upon realisation of a delays trajectory which remains ambitious and should it not be possible to deliver the closure of surge as forecast, a further £151k would be required to fund the surge in ED between January and March. This would then remain under review.

While Surge Staffing is considered out of the scope of the Core-ED, the two are intrinsically linked. Recommending a workforce without recognizing the need to consider surge staffing would pose an additional risk; namely that during periods of extremis there would be an inability to staff (either nursing or medical) any surge capacity. This is captured as part of Risk 4171 – Requirement to open additional capacity out with current footprint – graded as medium.

Therefore, in line with the recommendations below, consideration should be given to:

1. providing surge staffing until 31st March 2024 at a cost of £516k;
2. ensuring the required resources are part of a comprehensive implementation plan; and
3. close monitoring of improvement work designed to reduce system wide pressures

6 Recommendations

6.1 Medical

The summary described in 3.3.4 above describes Options 3 as the proposed model for Medical cover in the ED. This model has been considered advantageous, and appropriate for the BGH. Despite the workload tool and professional judgement options offering closer compliance against the drivers for change, the risks attached to these options are considered out with organisational appetite:

- Safety in ED – One of the primary drivers for this workforce review is the need to provide better senior support in the overnight period. These options discounted bring an added risk that in order to support a 2 doctor overnight service, this would require a reduction in non-consultant daytime medical staffing

- Financial – NHS Borders is a Board with a rapidly increasing financial deficit. Further recruitment will significantly impact on the Board's ability to achieve its statutory obligation of break even without accessing brokerage. The Scottish Government have asked for a financial plan which breaks even over three years and NHS Borders at present cannot demonstrate a plan to achieve this so any continuing financial investment will make this objective even more challenging.

- Recruitment – The Borders General Hospital has attempted to recruit medical personnel to the ED on a number of occasions and failed. There is no evidence that enhancing the volume of senior medical professionals would have any further success in attracting candidates. The rurality of the hospital is also likely to impact the ability to recruit.

It is prudent to add that while this model can be considered more financially sustainable, it does show the NHS Borders as an outlier compared to other mainland Boards as shown in table 20, below.

NHS Board	**Population** * *(data from ISD 2021/2022)*	**Consultants in Post**	**Population per 1 Consultant**
Ayrshire & Arran	366,800	16	22,925
Borders	**116,020**	**2**	**58,010**
Dumfries & Galloway	148,790	4.6 - 8	32,346-18,599
Fife	371,910	11	33,810
Forth Valley	306,000	10.5	29,143
Grampian	584,550	17.5	33,403
Greater Glasgow & Clyde	1,200,000	71.8	16,713
Highland	235,540	6	39,257
Lanarkshire	319,020	30.5	10,460
Lothian	858,090	37.4	22,944
Tayside	416,080	19.7	21,121

Table 20 – Consultant Comparison

6.2 Nursing

The summary described 3.3.4 describes Option 3 as the proposed model for Nursing in the ED. The option has been considered against the drivers for change, advantages and disadvantages, and risks identified. An indicative feasibility analysis has concluded that this option has a reasonable likelihood of being realised and the risk of over establishment can be mitigated by review of further opportunities across unscheduled care as a whole.

This was identified as the preferred option because the workload tool provides an objective, nationally recognised analysis of workforce requirement. It is a credible tool referenced against real-time examples of demand on the ED during daily operations (as shown by appendix 6). Finally, the option has been ratified and considered clinically and financially appropriate by senior personnel across general management, finance and nursing.

6.3 ENP

Option 2: ENP led Minor Injuries (Enhanced Provision)- This assessment concluded that one 11.5-hour shift per day and one 8-hour shift for 7 days would be sufficient to fulfil the current demand.

The clinical assessment was necessary due to the workload tool and professional judgement providing significantly different resource requirements. The workload tool was run during a two-week period and produced a requirement for 1.9 WTE registered nurses. During the professional judgement discussions with the senior nurses and management in the Emergency Department it was stated that the requirement for ENPs was 4.9 WTE registered nurses. Therefore, this further assessment had to be carried out and considered against the backdrop of demand, potential levers for support and overall risk. It was considered that this shift breakdown provided safe coverage.

6.4 Clerical

Option 2: Professional Judgement – This option would mean cover 7 days per week up to the out of hours period covering the high activity period. This would mean that except during the out of hours period clinical staff would in the main not be required to cover clerical duties

6.5 Surge

This workforce review has demonstrated the link the safety implications in the ED and length of stay (in both delayed and non-delayed patients). There are currently whole system efforts underway across health and care systems, which cross organisational boundaries, to improve both these key metrics. The link between hospital occupancy and overcrowding at the front door is known and documented. While there is growing confidence that the work being undertaken by the Urgent and Unscheduled Care Programme Board will deliver the required benefits to mitigate the need for surge, there is cause to consider a bridging period where ED surge staffing is protected and funded (non-recurrently), while improvements are sustained. Figure 5 below, demonstrates both the link and opportunity associated with length of stay and 4-hour emergency access standard (and by proxy, the increase in patient safety across the ED):

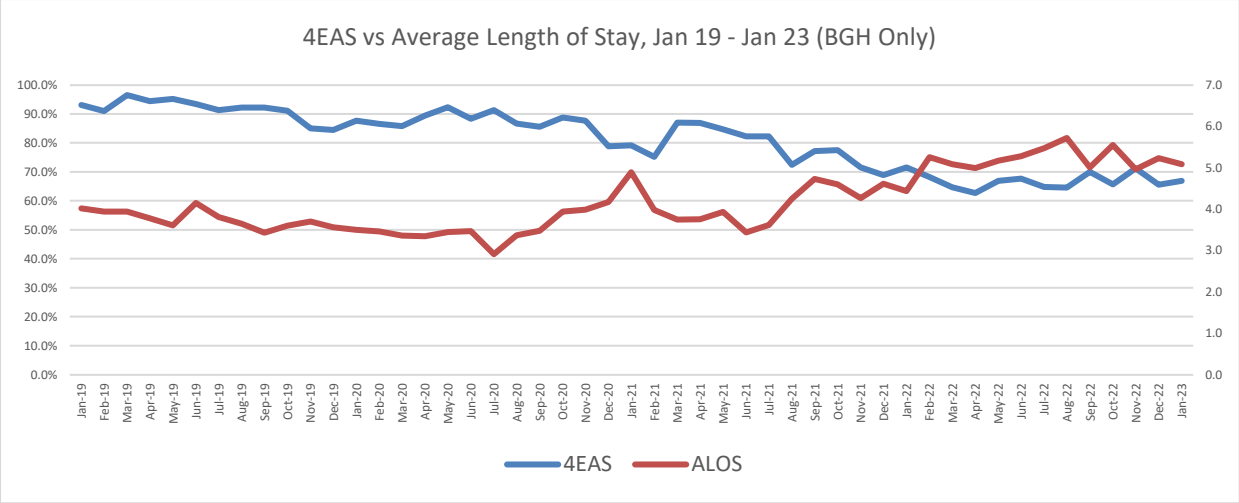

Figure 5 – 4EAS vs. Average Length of Stay Jan 19 – Jan 23

As shown above, returning to a pre pandemic length of stay has a positive impact on the 4-hour emergency access standard. As mentioned in 2.3, simply put; the emergency access standard is a safety metric, and broadly, improving safety (reducing clinical risk, improving senior decision making etc.) is the focus of this review. It is recommended that a period of non-recurring funding is agreed for 12 months. This allows adequate time for the improvements associated with the Urgent and Unscheduled Care Programme Board to come to fruition.

There are risks already on the risk register referring to the opening of surge capacity without the appropriate level of staffing and/or the impacts of congestion in the department. These risks have the following Risk IDs: 4397 (Very High) 4472 (High), 4171 (High).

7. Conclusion

As described throughout this review, NHS Borders is currently experiencing a prolonged and persistent period of pressure derived from a number of complex issues. These complex issues have resulted in an ED workforce that is no longer fit for purpose, nor adequately equipped to manage the pressures across a 24-hour period.

This workforce review recommends that a period of support is identified to support surge capacity in the ED, and evaluated as the implementation plan for the workforce is developed. While the financial impact of surge staffing is significant, there are opportunities to consider how the workforce can be utilised across the hospital system, should the need for surge capacity reduce in line with improvement activity planned.

Table 21 recommends the preferred option for Medical, Nursing, ENP and Admin and Clerical Roles in the ED. Detailed staffing models for both the preferred option and the current staffing can be found in Appendix 5.

Option	Description	Cost of Preferred Model £000s	Cost of Current Model £000s
Medical			
Option 3	EM consultant (3 WTE) Monday – Friday (supported by current in hours daytime rota) and 2 Doctors on night duty	£2,363	£1,720
Nursing			
Option 3	Days (in-hours) 1 WTE SCN, 5 RGN, 1 HCSW Night (out-of-hours) 4 RGN night duty, 1 HCSW nights	£1,720	£1,275
ENP			
Option 2	1 x 11.5hr shift & 8hrs shift 7 days per week working with nursing and medical team	£275	£212
Admin and Clerical			
Option 2	1 clerkess 9-9.30pm 7 days per week	£93	£54
	Total Cost of Models	£4,451	3,261
	Increase in cost current ED workforce model to preferred model		£1,190

*Table 21 – Final Recommendations- * medical staff costed at 22/23 pay rates as on agreement on pay award for 23/24*

It must be acknowledged that no single approach, model or intervention can address the very complex issues that impact an ED, or indeed the wider health and care system. Systems must adapt to their own challenges and be appropriate for their population, geography and local set up. Standards and guidance help provide a framework in which each system should operate. Above all, focused activity must be derived from evidence based best practice to ensure the ED remains as *safe as possible*. Good governance, underpinned by a robust and engaged workforce is the key to ensuring ongoing oversight and safe practices are maintained in across the ED.

The Borders General Hospital is ready to proceed with this proposal and are committed to ensure the necessary resources are in place to manage it. Governance support will be provided through existing fora including the now established Clinical Management Teams, Acute SMT and the Urgent and Unscheduled Care Programme Board.

Engagement with Stakeholders is detailed in section 5.1 and includes information on how the stakeholder members have been involved in the development of this workforce review.

8. Citations

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Sources:ISD(S)1 TrakCare

9. Appendices

9.1 Appendix 1 – Demographics

Scottish Borders Population

- The population of Scottish Borders is approximately 115,000. This makes it a medium-sized Scottish Council Area in population terms, only with a bigger land area and a lower population density than most other areas.
- The population of the Scottish Borders increased by an above average 8.5% between 2001 and 2021.
- Females make up 51.3% of the Scottish Borders population, similar to Scotland as a whole. This is because women tend to live slightly longer than men.
- The 45-64s age group make up an above-average 30.2% of the Scottish Borders population.
- The 16-24 age group made up a below average 8.7%.
- The number of people within the 25-44 age group fell by 22.9% in Scottish Borders between 2001 and 2021, much worse than the 2.1% decrease in Scotland as a whole.

Population projections

- The population is projected to increase by a below average 1% between 2018 and 2028, when all the effects of births, deaths and migration are considered
- An estimated 4,379 more people in Scottish Borders will die than be born in Scottish Borders between 2018 and 2028 - this is known as "natural change". This means that the population would decrease by an above-average 3.8%, if it were not for the effects of immigration - i.e. people coming into the region from elsewhere in Scotland, the UK or outside the UK.
- Immigration is expected to boost the Scottish Borders population by an above average 4.8%, which will help offset the natural decrease in the population.
- The 75s and over age group is projected to increase by an above average 29.6% between 2018 and 2028.
- The 45-64 age group will shrink by a worse-than-average 10.8% in the same period. The number of children aged 0-15 will reduce by 6.3%, which is similar to Scotland as a whole.
- Projected population estimates (2018-based, up to 2043) by age group and gender, with varying assumptions about migration, fertility, mortality etc., are available from the Scottish Official Statistics Open Data platform.

Life expectancy

- In 2019-21, life expectancy at birth (LEB) in Scottish Borders was estimated at 82.5 years for women and 79.7 years for men (compared with 80.8 and 76.5 years respectively in Scotland).
- Life expectancy has improved faster in the Scottish Borders than in Scotland for both men and women since 2001.
- In 2019-21, life expectancy for people aged 65-69 (LE65-69) was estimated in Scottish Borders at a further 20.6 years for women and a further 18.8 years for men (compared with 19.7 and 17.4 years respectively in Scotland)
- LE65-69 has improved faster in the Scottish Borders than in Scotland as a nation for both men and women.

- Statistics on Life Expectancy and Healthy Life Expectancy (HLE) by age, gender, SIMD quintile and urban-rural classification are available from the Scottish Official Statistics Open Data Platform.
- More information is available to download on healthy life expectancy.

9.2 Appendix 2 – ED Metrics

The Key performance indicators (KPIs)/measures for the ED include National and Local metrics and recommendations from the Royal College of Emergency Medicine (RCEM):

ED Specific	
Emergency Access Standard (EAS)	The National 'standard' for the emergency access standard is 95%. The current target (agreed with SG) is 85%. Performance across Scotland was recorded at 62.9% for the week ending 19 March 2023. The performance for NHS Borders during the same period was 57.4%. Above all the 4 hour EAS is a safety metric.
No 12 hour waits for admission beds	4, 8 and 12 hour waits can be considered as a patients breaching the standard above. These breaches are often the result of a wait for an inpatient bed. Within the context of an ED, the number of patients breaching is a critical indicator as to the safety within the department. There were 1,424 12 hour breaches across Scotland for the week ending 19 March 2023. During the same period, NHS Borders recorded 65 12 hour breaches.
Occupancy	Occupancy across the ED and wider hospital contribute to the level of care and safety of the site. Between Summer 2022-April 2023 the BGH regularly operated at an occupancy of >95% to manage unscheduled activity. Additional surge beds have been opened to manage this activity. During the same period the ED has operated at >100% requiring the opening of additional surge capacity. Taken collectively, the ED has had multiple of periods of running at 185% occupancy.
Attendances	Attendances and more specifically the volume of attendances during defined time periods have a direct impact on the ability to provide safe, patient centered care. Additionally, they are a contributing factor to periods of overcrowding. Comparing average attendances from 2019 and 2023 shows a negligible decrease in attendances (<1%) however several factors must be considered when considering the impact of attendances on overcrowding in ED: 1) increases in complexity and acuity of patients, 2) overall increase in patient volume i.e. the volume of patients arriving consistently hour on hour, 3) managed care problems, 4) lack of IP beds leading to overcrowding 5) avoiding IP admission due to intensive therapy in ED due to 4) (Derlet, R.W. and Richards, J.R., 2000)
Time to Triage	Time to initial assessment is the time from arrival at ED to the time when a patient is assessed by an emergency care medical or nursing professional to determine priority for treatment. There is no National target for Time to triage the emergency access standard should be applied
Scottish Ambulance Turnaround times	There is potential for clinical risk and harm occurring to patients affected by ambulance delays, with potentially some level of harm being experienced in 85% of patients where the handover is greater than 60 minutes, as well as potential moral injury to staff. The offloading of patients from ambulances into already overcrowded Emergency Departments and receiving areas also has the potential to cause harm.

Clinical Indicators	
Major Trauma outcomes	There is major trauma centers (MTCs) across Scotland. The nearest MTC to NHS Borders is NHS Lothian. NHS Borders should provide clinical expertise and capacity to stabilise and provide initial assessment of care needs prior to transfer to NHS Lothian. The outcomes include the time to Computerised Tomography (CT), time to antibiotics for open fractures and the EM consultant review of all major trauma patients.
Interdependent Indicators	
Length of Stay	The length of stay of (delayed *and* non-delayed) patients has a detrimental impact to achievement of the access standard, and safety metrics across the front door – this usually manifests itself in longer than usual waits for IP beds, congestion and higher than acceptable levels of occupancy across the hospital setting. Extended lengths of stay also increases the cost associated with healthcare and also the probability of Hospital Acquired Infection (HAI) which in turn increases average LOS by 9.32 days (Hassan, M., et al, 2010).
Delayed Discharges	A delayed discharge is a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date (Bryan, K., 2010). The cause of delays are multifactorial and include: insufficient capacity in next place of care to support discharge, unclear treatment planning, unclear dependency, unclear treatment end point, unclear out of hospital plans/task duration, poor communication of changes, and mis-synchronisation (dis-jointed MDT, subjective prioritisation and local silos). The average number of delays.

9.3 Appendix 3 – Required Standards and Skill Set

The RCEM Workforce Recommendations (2018) has defined a ratio of 1 WTE Emergency Medical (EM) consultant to between 3,600-4,000 new attendees. This is dependent on complexity of workload and associated clinical services for which the ED is responsible.

RCEM (2018) recommends staffing levels based on the size banding of the ED. For an ED managing < 60,000 attendees, it is recommended that a minimum of 6 WTE consultants are required for 12-16hrs per day.

The importance of EM consultant led care is well documented and studies have shown an increase in patient morbidity and mortality where there is a delay in involvement of an EM consultant in their care. The College of Emergency Medicine (CEM 2015) recommends a minimum of 10 EM consultants per ED with more for larger EDs or EDs with Major Trauma centers. Examples of the EM consultant and what can be delivered by their involvement is summarised below:

- A single EM consultant cannot be allocated to more than 1 role at once: running/oversight of the ED, involvement of resuscitation or complex procedures, rapid assessment, and training. All these activities required dedicated personnel;
- Where a department has less than 10 EM consultants, it is difficult to provide the level of care sustainably over weekdays and weekends. The impact of a poorly staffed consultant body is extended hours, higher levels of demand, stress and an altogether poorer staff experience; and
- Where a department has 10 EM consultants, the department has the capacity to deliver 1 EM consultant providing oversight of ED at all times during core hours (8am-8pm) 7 days per week with some doubling up in the afternoons, evenings and some weekend cover.

There are specific ED clinical roles the EM consultant delivers including: *(this is not an exhaustive list)*

- Command and Control/Emergency Physician in Charge (EPIC);
- Resuscitation;
- Supervision of streamed areas e.g. Minor Injuries, acute assessment;
- Initial assessment (12-16hrs, over 7 days);
- Consultant delivered patient care;
- Clinical and departmental governance and
- Clinical supervision of junior and trainee doctors, ENPs, ANPs and trainee practitioners.

The overall sustainability of the EM consultant is essential and some key principles are recommended when planning the future workforce model. These include maximising safe working practices and working a significant part of their time overnight to allow more proportionate time off so that they have time to rest, recover and recuperate from the intensity of the working environment.

Supporting and developing of less than full time working posts and taking into account the age of the workforce is crucial in retaining experienced doctors as well as growing a sustainable workforce (RCEM 2018).

The Royal College of Nursing (RCN) and RCEM (Nursing workforce for Type 1 EDs 2020) defines EDs as:

- Type 1 department – major A&E, providing a consultant-led 24-hour service with full resuscitation facilities
- Type 2 department – single specialty A&E service (e.g. ophthalmology, dentistry)

- Type 3 department – other A&E/minor injury unit/walk-in centre, treating minor injuries and illnesses

The standard for Emergency Nurse (EN) compromises a minimum of 80% registered nurses with a skill mix of:

- 30% Emergency charge nurses
- 40% Emergency Nurses
- 10% Registered nurses
- 20% Clinical support workers

This skill mix ensures sufficient Emergency Nursing capacity to deliver safe clinical care, providing supervision of registered nurses, student nurses and clinical support workers.

The standards for delivery of safe efficient care include: (RCN/RCEM 2020)

- Clinical Coordinator (Emergency charge nurse band 6/7) on duty 24/7 in addition to the nursing workforce;
- Emergency Charge nurse or an EN with level 2 competencies to be the nominated shift lead for the resuscitation area;
- Minimum of 1 registered nurse to each resuscitation area;
- Minimum of 1 Emergency charge nurse/EN to undertake initial assessment/triage 24/7;
- Minimum of 1 RN to 3 cubicles where moderate and high dependency patients are nursed;
- Dedicated pediatric EN where EDs receiving pediatric activity and
- A nursing workforce complemented by other staff such as clinical support workers, receptionists, ward clerkess, porters and housekeepers.

Local context must be applied to ensure the ED remains viable and is able to function within clinical and financial constraints

9.4 Appendix 4 – Workforce Tool Findings

BGH – EMERGENCY DEPARTMENT – EDEM AND PROFESSIONAL JUDGEMENT TOOLS: 10-23 Oct 2022			
REPORT WRITTEN BY: L BOYLE		**DATE: 15/12/2022**	
BOXI REPORT	**FUNDED ESTABLISHMENT:**	**22.74 wte** [20.59wte RN/2.15wte HCSW] + **3.39wte** ENP **14.10 wte** [medical] of which **2.20wte** are consultants [a variety of medical cover is provided by other clinical specialties)	**COMMENTS** Notably the ED footprint has changed with ED2 being utilised at times, introduction of MIU and effects of BUCC introduction. Impact seen from changes to practice in pandemic. Inability to achieve compliance with 4hr EAS has led to long bed waits in ED thus increasing workload. ENP staff also provide cover to MIU. PDF EDEM Roster 201222.pdf Output figures from workload tools include 22.5% PAA although NHSB includes 21% in departmental budgets. Professional Judgement may be influenced by pressure in department, skill mix, long patient waits, staff fatigue
	ESTABLISHMENT BEING WORKED TO CURRENTLY - NURSING	**35.32wte** [nursing - 23.58 RN; 3.39 ENP; 7.79 HCSW] – Establishment being worked to at time of tool run.	
	ACTUAL IN POST:	**Actual Nurse Staffing in post** during tool run = **33.46wte**: 24.34 wte RN; 3.95wte ENP and 5.53wte HCSW (includes 2.99wte RN and 2wte HCSW on maternity leave) **Medical Staffing in post** – **14.41wte** of which 2.11wte is Consultant (including Locum) and 12.30wte non-Consultant. The medical staffing includes fixed term CDF posts. The hours covered by the Ortho GPST/other specialties are not part of the ED budgeted establishment. [Actual medical staff working over 2 weeks averaged 1.0wte Consultant and 10.73wte non-consultant grades] *Information sourced from ED medical staffing budget statement and SSTS.*	
	CURRENT VACANCIES:	No current vacancies due to working above funded establishment but SCN reports some outstanding recruitment in progress.	

	STAFF TURNOVER RATE: [2022]			8 LEAVERS [headcount] and 4 NEW STARTS [headcount] – Nursing I consultant and 1 Specialty doctor left department. Turnover further impacted by staff reducing hours within current posts.					etc. Please note PJ around Band 6 cover.
	WORKLOAD TOOL RESULTS:			**Medical** **18.8 wte** [6.0 consultant and 12.8 Non-consultant]		**Nursing** **37.5wte** [30 RN and 1.9 ENP and 5.6 HCSW]			
	PROFESSIONAL JUDGEMENT TOOL RESULTS:			**Medical – 18 wte** [5 consultants and 13 non-consultants] **Nursing – 41.67 wte** [33.7RN of which 4.9 ENP; 7.9 HCSW]					
TOTAL TIME OUT during October **25.55% [N&M-- REG]** **30.85% [N&M– HCSW]** **26.89% [MEDICAL]**	**PAA** **21%** **21%** **25%**	**AL** **15.43% (RN)** **8.76% (HCSW)** **13.07%**	**Sickness** **9.18% (RN)** **22.10% (HCSW)** **13%**		**STUDY** **0%** **0%** **0%**	**SPECIAL** **0.71%** **0%** **0.37 + 0.45% Covid Leave**	**OTHER LEAVE** **2.99wte RN and 2wte HCSW on Mat Leave** **Special leave predominantly Covid leave**	**COMMENTS** **With exception of June 2022, sickness absence levels have been consistently above 4% in the last year ranging from 1.5%-11.4%. There has been a significant increase in special leave in the last 3 years, presumably attributable to Covid infections. Annual Leave allocation has ranged from 8-16%. Study leave allocation has been frequently under 2% and frequently less than 1%. (N&M). HCSW headcount availability has been low at times due to recruitment delays and sickness.** **(Medical) – Frequent periods of 0% study leave. AL allocation has ranged from 3.9-14.6% monthly. Sick leave has ranged from**
TOTAL TIME OUT average over 6 months **22.2% [N&M - RN]** **24.37% [N&M– HCSW]** **16.26% [MEDICAL]**	**21%** **21%** **25%**	14.1% 9.25% 10.3%	6.33% 13.53% 3.8%		0.9% 1.2% 1.13%	0.05% Covid Leave 0.17% 0.61% Covid Leave	0.81% 0.22% 0.42%		
BANK/AGENCY USAGE during tool run	**BANK REGISTERED NURSING:**		**65hrs over 2 weeks (0.87wte/week on average)**	**AGENCY REGISTERED NURSING:**			**86 hrs over 2 weeks (1.15 wte/week on average)**		

					0% to a peak of 13% in October. Total leave has been from 7.9-33.9% monthly.
			AGENCY MEDICAL:	**0.81wte Consultant Locum**	
	BANK UNREGISTERED HCSW:	**149.5 hrs over 2 weeks (2.17 wte/week on average)**	**AGENCY UNREGISTERED HCSW:**	**11.5hrs/2 weeks (0.15wte/week on average)**	
OVERTIME/EXCESS HOURS during tool run	**REGISTERED NURSING:**	**0.43 (wte per week)**	**UNREGISTERED NURSING:**	**0.05 (wte per week)**	

LOCAL CONTEXT

The Emergency Department is open 24 hours a day within the Borders General Hospital and is staffed at all times by a team of medical and nursing staff. A Minor Injury Unit (MIU) is housed within the department and is staffed predominantly by ENPs. 'Blue ED' in the previous Orthopedic Clinic area opens to provide care when the department numbers are high and is also staffed by ED nursing and medical staff.

The emergency department main functions are:

- to provide immediate attention to people with life-threatening problems;
- to treat patients who have injuries as a result of recent accidents;
- to assess and treat people who have been referred by a GP.
- Contact mental health services if necessary.

The main ways to access our service is:

- GP/BUCC Referral
- Self-referral
- Urgent Ambulance

QUALITY INDICATORS

FALLS
ED have had between 1-7 falls recorded per month in the last year. Within that period of time there have been a total of 7 falls with harm recorded.
PRESSURE DAMAGE
10 pressure damage (inherited) events were recorded in Emergency Department. Whilst ordinarily ED may choose not to audit some quality indicators, it would be appropriate to consider specific QIs in light of frequent breaches of EAS and lengthy waits in ED for frail, elderly or vulnerable patients. Harm reduction rounds have been implemented but are not consistently achieved.
FOOD FLUID AND NUTRITION
3 nutrition events recorded in Emergency Department. Whilst ordinarily ED may choose not to audit some quality indicators, it would be appropriate to consider specific QIs in light of frequent breaches of EAS and lengthy waits in ED for frail, elderly or vulnerable patients. DNMAHP has asked for weights and MUST scores to be prioritised within 12 hours of arrival in ED but this standard is not being met currently.
4 HOUR EMERGENCY ACCESS STANDARD
Throughout 2022 the 95% stretch target of NHSB has never been achieved. A 90% national target has also not been achieved. This has significantly declined in the last 2 years as the Covid19 pandemic has continued to impact services. Average weekly compliance in the last year has ranged from 55% to 78%. This illustrates that the department has been under significant pressure throughout the year due to a variety of reasons, frequently waits for medical beds as flow through and out of the hospital has stalled, primarily due to the pressures on social care.
DATIX REPORTS
Traceability compliance for blood transfusion improved markedly through 2021 but with some degree of variability in 2022 although this looks to be improving. In the year leading to the run of the workload tool, 231 Adverse Incident Reports were submitted with the 4 highest numbers being: Staffing Levels [51]; PMAV [45]; Falls [35] and Medication events [24]. One event was reported as extreme and 3 were reported as major. 17 near miss events were recorded - likely still to be an element of under reporting. Additional issue is that there are a significant number of Adverse Incident Reports that are not signed off due to pressure on SCN ≥75.
TRAINING & PROFESSIONAL DEVELOPMENT

Up to end of November 2022 no appraisals have been recorded for ED. This needs to be viewed in context of some work being stopped as a result of COVID Pandemic. However, the majority of staff have no appraisals/objectives recorded in previous 3 years.

ED has recorded 64.7 % compliance with nine core statutory/mandatory e-learning modules.

%AER	%ED	%Fire	%IC	%IG	%MH	%PMAV	%PP		% Compliance
77.8	88.9	42.2	73.3	51.1	46.7	71.1	66.7		64.7

COMPLAINTS AND COMMENDATIONS

There has been a fairly sustained increase in the number of Stage 1 and Stage 2 complaints over the last year – this is most likely attributable to the increased pressure on the department and associated lengthy waits for many patients but needs clarification. Commendations have a documented marked decrease in numbers – possibly for the same reasons outlined above but may also be a reporting anomaly (under reporting).

DATA OVERVIEW

ED SCN QUALITY DASHBOARD_17.pdf

There has been a significant overspend each month on staffing - associated with vacancies, sickness absence and special leave – use of excess/overtime hours as well as agency and bank spending (supplementary staffing).

Reported medication errors remain reasonably infrequent but have shown a bit of an increase over the last year – this could be due to staffing levels, pressure within the department, skill mix etc. but clarification required through review of all errors.

Data does warrant further questioning in terms of accuracy e.g. no maternity leave has been recorded via SSTS in ED despite there being 4 registered nurses on maternity leave in this financial year. As a result this does not show on Scorecard nor on Tableau which distorts the overall reporting of pressures in the system.

SUPPLEMENTARY STAFFING

Throughout 2022 monthly supplementary staffing usage has been significant with 1.5 – 3.5wte Registered Nurses working a mixture of excess part time hours, overtime, Bank and Agency. For HCSW the monthly usage has ranged from 0-2.1 wte – predominantly Bank staffing with some excess/overtime hours worked.

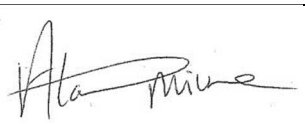
It is well documented that use of Bank and Agency can be detrimental to patient care and using permanent staff to work additional hours can have a negative impact on staff well being e.g. fatigue of working in department already under pressure. Staff unfamiliar with the department can also add to the stress and workload of existing staff in terms of supervision and support required.

Medical Agency Spend was on Consultant Locums.

ACTION PLAN & RECOMMENDATIONS

- Review the completeness of measuring clinical quality indicators in ED – pressure damage and Food, Fluid and Nutrition standards given the long waits/reduced patient flow and the decreased conditioning of patients presenting throughout the pandemic.
- Consider improvement options e.g. harm reduction rounds; recording of weights/MUST scores within 12hrs of presentation to ED and how to maintain consistency.
- Provide adequate time for professional leads (nursing and medical) to carry out leadership role in order to optimise meeting staffing and service requirements.
- Ensure that sickness absence is robustly managed – consider reasons for absence and look at spikes and trends to identify any actions that need to be taken to address these e.g. OHS support for staff suffering stress/anxiety; ensure Manual Handling up to date to prevent MSK injuries; ensure PMAV training appropriate to enable staff to manage aggressive patients etc. Ensure proper use of PPE to prevent spread of Covid or other infections within the department.
- Ensure compliance with rostering policy and manage time out, particularly in relation to level loading of AL. Observe levels of special leave being allocated.
- Keep on top of recruitment for department and identify issues and blockers to recruitment, escalating these to managers and Regional Recruitment Team.
- Use of Exit interviews to gain insight into reasons for attrition.
- Develop plan to complete appraisals to identify staff training and development requirements.
- Clarify accuracy of data submitted via SSTS e.g. maternity leave and also training and development and develop plan for staff to achieve compliance with statutory/mandatory training as well as department specific training requirements.
- Consider increase in complaints and decrease in commendations and identify how/where improvements could be made.
- Look at reasons for medication errors within the department to identify any trends.
- Provide evidence of real time staffing escalation and actions taken e.g. safety brief/safety huddles.
- Identify method of feeding back findings of tool run to staff team.
- Ensure Workload Tool report is shared with CMT and through appropriate governance structure.
- Consider environmental improvements needed in light of long patient waits in department e.g. lack of toilet and washing facilities, meal and drinks provision, access to call bells, availability of trolleys and beds, waiting area facilities
- Identify changes required to funded establishments and/or service provision and write business case to present to Board.

MANAGER SIGN OFF	
Signature of SCN/Team Manager:	

Signature of Clinical Nurse Manager:	
Signature of ADoN:	

9.5 Appendix 5 – Example Rota

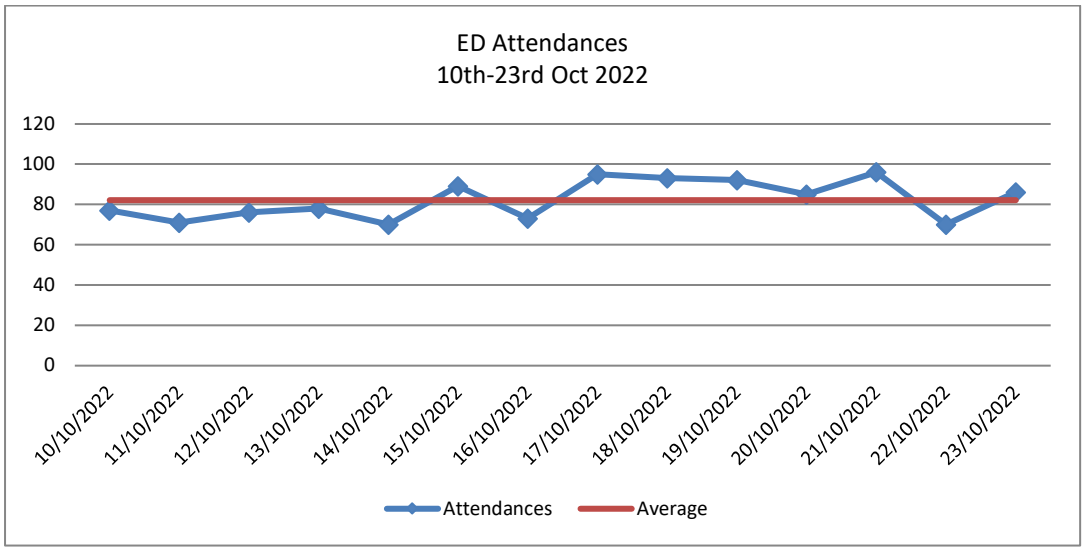
Current ED rota for paper.xlsx

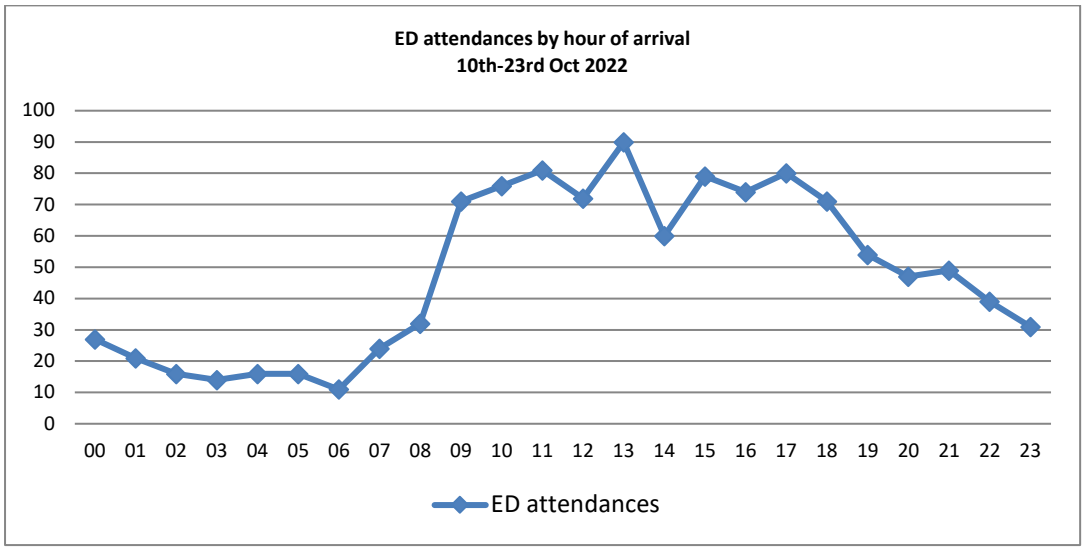
9.6 Appendix 6 – Activity Breakdown during Workforce Tool

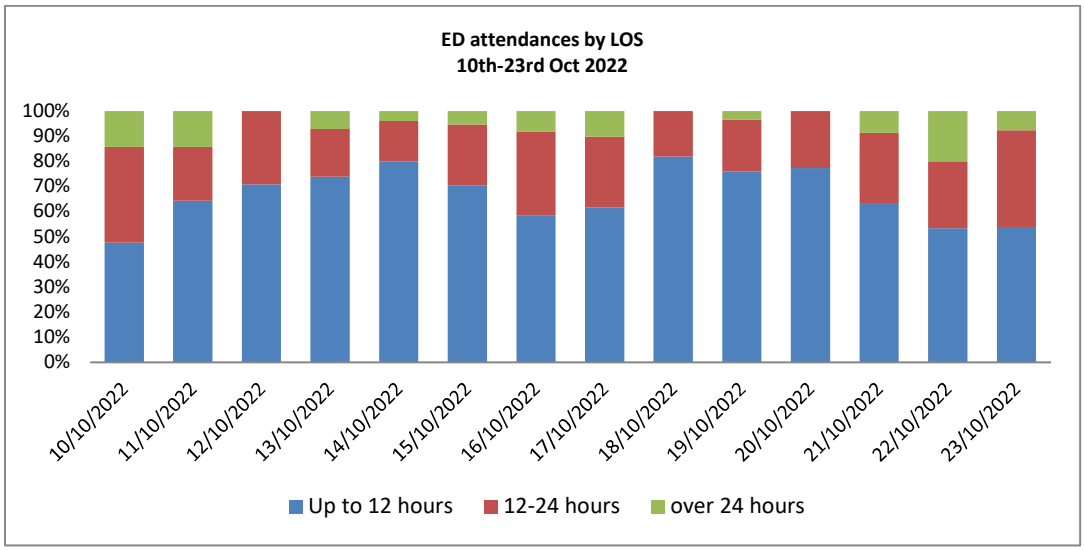
The workload and professional judgment tool was carried out in from 10th to 23rd October 2022 and involved both the nursing and medical team. The following operational pressures were observed:

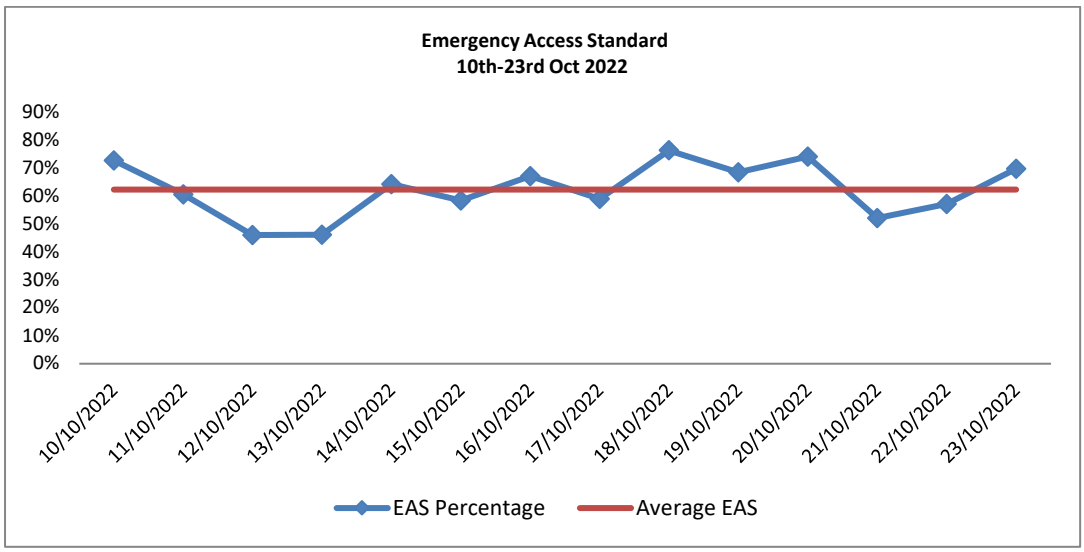
			Staffing Gaps at 8.30am		
Date	**Patients in Department at 8.30am**	**Patients Awaiting Admission at 8.30am**	**RGN**	**HCSW**	**RAG Status**
10/10/2022	18	11	1	1	
11/10/2022	20	12	2	1	
12/10/2022	18	7	2	2	
13/10/2022	21	12	1	2	
14/10/2022	25	12	2	2	
15/10/2022	8	5	1	1	
16/10/2022	16	9	1	0	
17/10/2022	14	11	2	1	
18/10/2022	24	13	1	2	
19/10/2022	4	1	1	0	
20/10/2022	14	7	2	1	
21/10/2022	17	6	2	1	
22/10/2022	15	14	1	1	
23/10/2022	19	13	0	0	

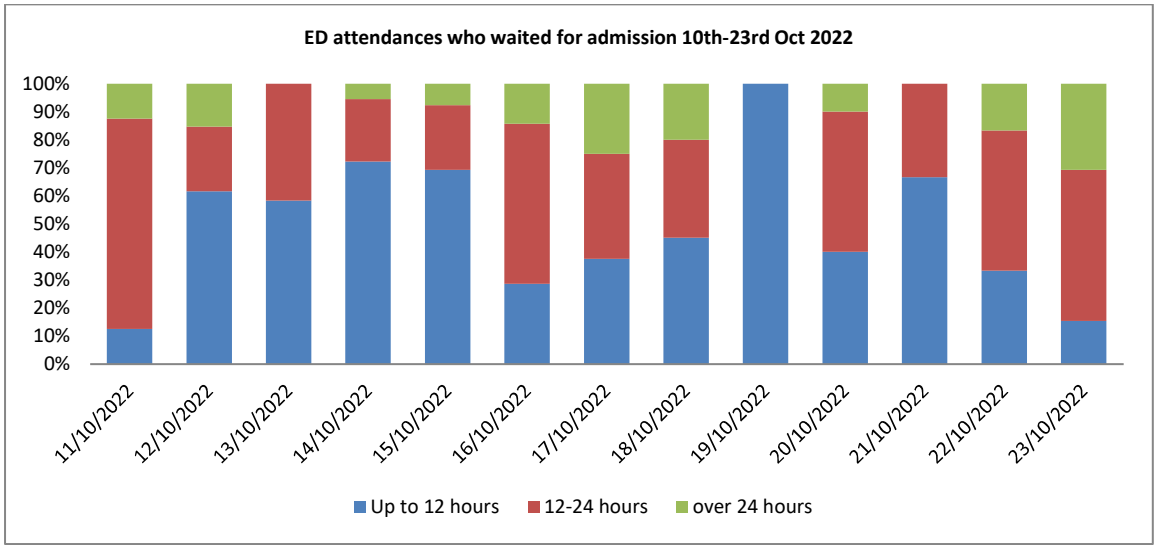
Over the course of the recording weeks, weekly attendances were considered average at 535 and 611 attendances. During the recording period 4, 8 and 12 hours waits for admission were comparable to the weeks previous with 70 patients both weeks spending 12 hours or more in the department. Breakdown of data activity for the 2 weeks is shown in the graphs below:




ED attendances by hour of arrival
10th-23rd Oct 2022
100
90
80
70
60
50
40
30
20
10
0
00 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23
ED attendances


ED attendances by LOS
10th-23rd Oct 2022
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
10/10/2022
11/10/2022
12/10/2022
13/10/2022
14/10/2022
15/10/2022
16/10/2022
17/10/2022
18/10/2022
19/10/2022
20/10/2022
21/10/2022
22/10/2022
23/10/2022
Up to 12 hours
12-24 hours
over 24 hours


Emergency Access Standard
10th-23rd Oct 2022
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
10/10/2022
11/10/2022
12/10/2022
13/10/2022
14/10/2022
15/10/2022
16/10/2022
17/10/2022
18/10/2022
19/10/2022
20/10/2022
21/10/2022
22/10/2022
23/10/2022
EAS Percentage
Average EAS


ED attendances who waited for admission 10th-23rd Oct 2022
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
11/10/2022
12/10/2022
13/10/2022
14/10/2022
15/10/2022
16/10/2022
17/10/2022
18/10/2022
19/10/2022
20/10/2022
21/10/2022
22/10/2022
23/10/2022
Up to 12 hours
12-24 hours
over 24 hours

Scottish Borders Health and Social Care Partnership
Integration Joint Board

20 September 2023

Unscheduled Care Surge Planning and Delayed Discharge Trajectory Update

Report by Chris Myers, Chief Officer

1. PURPOSE AND SUMMARY

1.1. **To appraise the Integration Joint Board of progress following its consideration of the need for enhanced surge planning and the associated direction that was approved in its meeting on 19th July 2023.**

1.2. The Direction followed escalation by the Health and Social Care Partnership (HSCP) Joint Executive to the Integration Joint Board based on deteriorating local unscheduled care performance, and the increased associated risk.

1.3. A new surge plan and associated delayed discharge trajectory and associated surge plan is enclosed that has been approved by the Health and Social Care Partnership (HSCP) Joint Executive Team, and considered by the NHS Borders Resource and Performance Committee.

1.4. As this is a complex plan, involving actions from across the HSCP, there are a number of risks associated with this plan, but work will be undertaken by the HSCP Joint Executive Team to manage performance and risk as effectively as possible.

2. RECOMMENDATIONS

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

a) Note the progress made by the HSCP Joint Executive Team on actions which support surge planning
b) Note the delayed discharge trajectory

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

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

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our efficiency and effectiveness	Reducing poverty and inequalities
X	X	X	X	X	X

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

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required

5. BACKGROUND

5.1. Further to the Integration Joint Board meeting which considered the position escalated by the HSCP Joint Executive Team, the approved direction was issued to NHS Borders and the Scottish Borders Council.

5.2. Officers within the Health and Social Care Partnership have held a surge planning workshop on 31 July 2023 to consider existing programmes of work under the HSCP Urgent and Unscheduled Care Programme Board that could potentially have a positive impact on hospital occupancy, that could be further accelerated, with minimal resource impact. Following the workshop, further work was undertaken to assess the risks and feasibility associated with these initiatives.

5.3. In addition, work has been progressed to outline the impacts of the additional £1.9m investment agreed for older adult services by the Integration Joint Board in their 2023/24 budget, and the associated Scottish Borders Council budget offer.

5.4. This paper notes the progress and outputs of this process. It must be noted that there a range of risks further outlined in the risks and mitigations sections (7.13 and 7.14).

6. OUTPUTS

6.1. The following areas of impact from an early intervention and prevention perspective have been identified:

- A focus on improving vaccination uptake for Health and Social Care staff to 75% uptake
- A focus on nutrition, hydration and anticipatory care planning in Care Homes
- Continued work to progress Hospital at Home
- Communications to promote self care, community supports, Values Based Health and Care and the Right Care, Right Place, Right Time agenda
- Commissioning of the third sector

6.2. The following areas of impact from a process and transformation perspective have been identified, with impacts on bed occupancy noted in brackets:

- Home to Assess as a core component of the integration of Home First and Adult Social Care Home Care services (impact of 18)
- Development of the Medications Administration service within Home First (impact of 15)
- Single assessment through a re-ablement assessment (reduced length of stay and improved process)

- Effective Discharge Implementation Programme (reduced length of stay and improved process)

6.3. The following areas of impact from an investment perspective have been identified, with impacts on bed occupancy noted in brackets:

- Improved carer supports, including the opening of 4 high dependency bed based respite
- Poynder Apartments (36 total units, with 9 forecast from the Hospital system)
- Upper Deanfield step down care and Waverley (9 giving forecast impact of 12 to the end March)
- Further commissioned step down beds (18 giving forecast impact of 33 to the end March)

7. IMPACTS

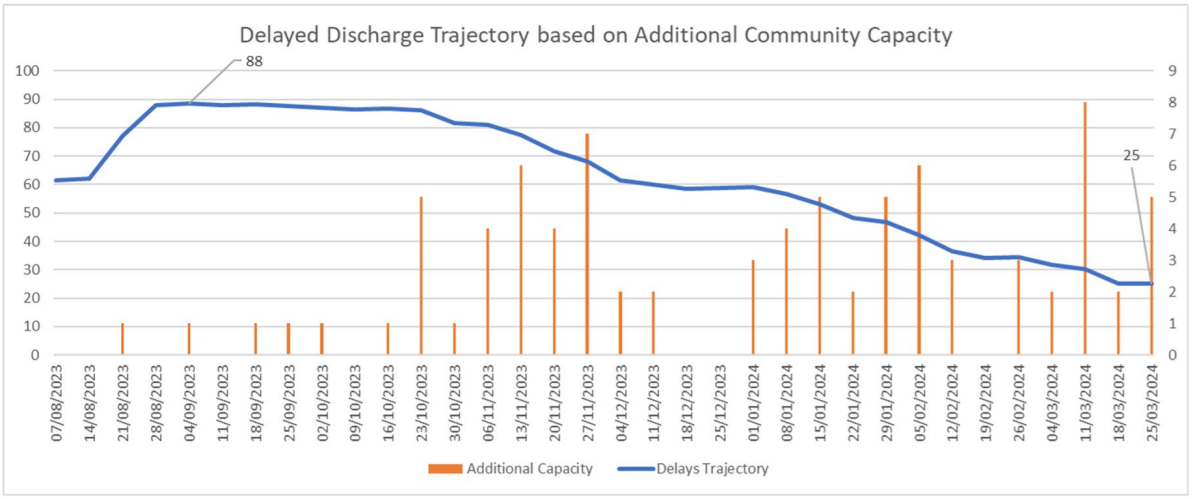
Community Health and Wellbeing Outcomes

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

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

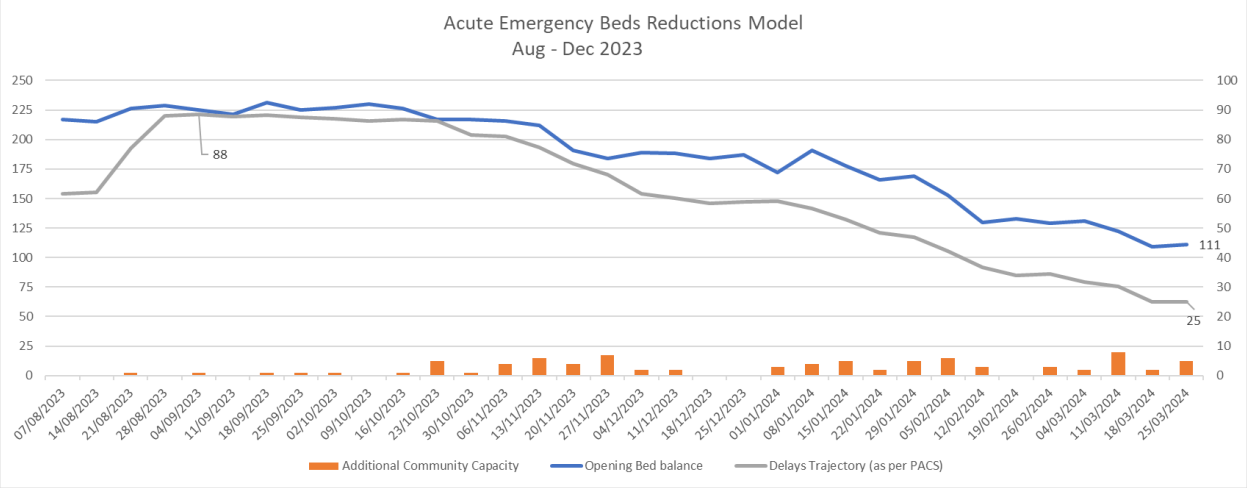
Delayed Discharge Trajectory

7.2. Based on an assumption that both core demand and activity remain as they were over the 26 week preceding period (27 February – 31 August 2023), with core demand of 12.8 / week versus core removals of 12.4 a week, and that the additional actions fully deliver, the additional actions noted above are expected to have the following impact on the number of Delayed Discharges across all hospital sites.



Surge Beds Closure in Borders General Hospital

7.3. In turn, based on bed occupancy from 22/23, the additional actions are expected to have the following impact on the number of Acute emergency beds required in the Hospital system.



Financial impacts

7.4. There is an opportunity for a reduction of large hospital set aside financial costs through the actions outlined in this paper to close surge beds. This would include the closure of Blue ED, surge in Ward 7 and Borders View surge.

7.5. The actions outlined are expected to reduce the nursing overspend from a baseline overspend of £148k/ month = £1,779k per annum, by £43k/ month. Over the remainder the financial year this would reduce the overspend by £392k to £1,387k.

7.6. Impacts are noted in the table below, but depend on the delivery of the actions described to enable closure of surge capacity, along with acute hospital occupancy aligning to the forecast.

Surge closure	Timescales and associated reduction in spend
Blue ED closed and 10 beds of the 37 in MAU ringfenced mid Nov	Mid Nov to March = **£194k**

Shutting surge in Ward 7 Mid December	Mid Dec to March = **£151k**
Shutting 8 beds in Borders View from Mid-January will reduce staffing in Borders View by 5.19wte HCSW	Mid-January to March **= £47k**
Baseline surge nursing staffing spend £148k/ month = £1,779k Spend reduced to £43k/ month with closure of surge noted Projected spend on surge beds in 23/24 with surge closure plan - £1,387k	
Total reduction in expenditure to March 24 - **£392k**	

Equality, Human Rights and Fairer Scotland Duty

7.7. Stage 1 Proportionality and Relevance has been completed. As this surge closure programme depends on the impacts of a range of other projects, associated Equality and Human Rights Impact Assessments are being undertaken, where relevant, for each of these projects.

Legislative considerations

7.8. The principles of integration set out in the Public Bodies (Joint Working) (Scotland) Act 2014 included ensuring that available facilities, people and other resources are used most effectively and efficiently, in a way that anticipates the needs (and prevents them arising) of a population with increased level of need.

7.9. Integration Authorities are responsible for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway, alongside primary and community health care and social care. This is known as the "Set Aside" budget.

7.10. The objective is to create a coherent single cross-sector system for local joint strategic commissioning of health and social care services and a single process through which a shift in the balance of care can be achieved.

7.11. Legislation permits that where a planned change is delivered resource will be able to be transferred between the Delegated Budget and the Set Aside budget for directed hospital services, via a Direction from the Integration Authority to the delivery partners. In the case of an increase in consumption, the Integration Authority will need to consider how to fund the additional capacity through the Strategic Plan. Similarly, where resource is released, the Integration Authority will be able to consider how to use this resource through the Strategic Plan.

Climate Change and Sustainability

7.12. There are no known climate change or sustainability impacts.

Risk and Mitigations

7.13. Unscheduled care surge pressures impact on IJB Strategic Risk 002: "If we fail to ensure the effective delivery of outcomes/delegated services within the available budgets then it could lead to poorer outcomes and an inability to deliver the Strategic Commissioning Plan / Strategic Framework." The approach outlined in this paper is expected to reduce this risk.

In addition, the following risks have been identified. These will all be closely managed through the HSCP Joint Executive, and the HSCP Urgent and Unscheduled Care Programme Board.

	Risk	RAG
Capacity	There is a risk that gains made through the closure of beds (offset by community capacity) still leaves the hospital at 100% occupancy	
	There is a risk that additional community capacity does not have a targeted length of stay/adequate turnover to ensure robust flow (externally)	
	There is a risk that the additional capacity released does not match the patients currently delayed in Acute, therefore the overall beds gain Acute is reduced.	
Occupancy/Surge	There is a risk that failing to achieve 90% occupancy on the funded unscheduled bed base will impact elective requirements	
	There is a risk that Acute surge is the only feasible surge action (Community Services unable to support surge actions)	
	There is a risk to delivery of elective surgery programme	
	There is a risk that additional community capacity does not provide ongoing flow across Acute which will exacerbate congestion/overcrowding in ED	
	There is a risk that the patients delayed across the Acute setting do not match the criteria set for Borders View	
Staffing	There is a risk that increased sickness absence due to increased levels of movement across BGH (proposed bed closures will require repurposing existing resource)	
Community Capacity	There is a risk that enabling meds administration will not deliver predicted gains. There is a risk that the integrated reablement project will not be able to go through the organisational change process/ restructuring in order to impact current DDs.	
Engagement	There is risk that this plan will be perceived inaequate by system partners based on historical commitments to Winter	

8. CONSULTATION

Communities consulted

8.1. Over and above the communities consulted through the individual underpinning projects, the following groups have been consulted:

- HSCP Urgent and Unscheduled Care Programme Board

8.2. Over the coming months, as the work continues to evolve, the following groups will be consulted:

- Unpaid Carers – Carers Workstream
- Staff – Joint Staff Forum
- GP Subcommittee
- IJB Strategic Planning Group

Integration Joint Board Officers consulted

8.3. The IJB Board Secretary, the IJB Chief Financial Officer, the IJB Chief Officer and Corporate Communications have been consulted, and all comments received have been incorporated into the final report.

8.4. In addition, consultation has occurred with our statutory operational partners at the:

- HSCP Joint Executive
- NHS Borders Resources and Performance Committee

Approved by:

Chris Myers, Chief Officer

Author(s)

- Chris Myers, Chief Officer

- Philip Grieve, Chief Nurse
- Bhav Joshi, General Manager, Acute Unscheduled Care

Background Papers:
Scottish Borders Health and Social Care Integration Joint Board 19 July 2023. Surge Planning. Available from: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6536&Ver=4

Scottish Government. Financial planning for large hospital services and hosted services: guidance. Available from: https://www.gov.scot/publications/guidance-financial-planning-largehospital-services-hosted-services/

Previous Minute Reference:
Scottish Borders Health and Social Care Integration Joint Board 19 July 2023. Meeting minutes, Surge Planning. Available from: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6537&Ver=4

For more information on this report, contact us at:
- Unscheduled Care Surge Planning : Bhav Joshi bhav.joshi@nhs.scot
- Delayed discharge trajectory : Philip Grieve philip.grieve@borders.scot.nhs.uk

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Mental Health and Learning Disabilities Medical Workforce Plan**
Responsible Executive/Non-Executive:	**Chris Myers, Director Health and Social Care**
Report Author:	**Simon Burt, General Manager, Dr Amanda Cotton, Associate Medical Director**

1 Purpose

To brief the Board regarding the Mental Health Boards medical workforce recruitment challenges and proposed mitigating actions. Board members are asked to consider their level of appetite to support the recommendations contained within this paper, which will be used to inform the payment offer from NHS Borders to the Health and Social Care Integration Joint Board

This is presented to the Board for:

- Decision

This report relates to a:

Emerging issue

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The senior medical workforce landscape is characterised by acute-on-chronic deficits and frequent, often rapidly emerging, changes. In addition to impacts on clinical governance and service safety, this has limited strategic planning and led to recurrent overspends in filling gaps using agency. This plan assumes the senior workforce situation is unlikely to improve quickly and will require initial investment to realise later clinical and financial stability.

2.2 Background

This paper focusses on areas of particular instability and current and anticipated funding gaps which represent financial and clinical risk to the organisation. Associated recommendations seek to minimise clinical risk, with the aim of ensuring continuity of service and to allow NHS Borders to plan according to the financial implications.

The medical staffing to the Mental Health and Learning Disability business unit is highly internally interconnected and interdependent with the wider multidisciplinary context. There is no 'neat' way to divide and analyse the situation; the paper attempts to do so in a high-level manner with the caveat that not all clinical and financial consequences can be fully anticipated or described. Each subspecialty area is discussed, with more in-depth analysis where needed. The senior and junior out-of-hours cover is discussed. Cover to the inpatient units is discussed as part of the foundational structure supporting senior functioning. Medical skill mix is referenced at appropriate junctures.

The tables below set out the current substantive medical staffing in post, locums in post and the net balance against establishment. In particular this highlights that of the Consultant establishment we only have 9.05 in post against an establishment of 15.8. Even with locums we are running 3.75 staff short of the establishment.

Table 1: MHLDS Consultant Medical Staffing

Team	**Cons establishment (WTE)**	**Substantive consultant in post from August 2023**	**Locum**	**Balance/notes**
Adult South	1.25	0.25	-	-1.0
Adult East	1.2	0	1.4	0.2*
Adult West	1.7	1.0	-	-0.7
Rehab	1.5	1.4	-	-
MHOAS	3.2	0.9	1.0	-1.3
CAMHS	3.6	2.1	0.6	-0.9
LD	1.0	1.0	-	-
Liaison	0.7	1.0	-	No recurrent funding stream for 3 sessions
BAS	1.0	1.0	-	Consultant expected to resign late 2023
Forensic	0.3	- (included in LD wte)	0.1	0.2 provided by LD cons without forensic CCT
Perinatal	0.25	0.25	-	
Inpatient	Included in relevant Est			See recommendation re Physician Associates
BCT	Included in adult Est			
ECT	0.05	0.05	-	Cross cover from those with competencies
Adult NDD	0.2	0.2		NAIT funding
Ed sup	0.05	0	-	-0.05
Total	**15.8**	**9.05**	**3.1**	-3.75

*1.0 agency locum on 3-month contract; 0.4 senior consultant on 1 year contract

Table 2: Senior Medical General Out-Of-Hours Rota Staffing

On-call	8	5.5	-	-2.5

Table 3: 'Junior' Medical Out-Of-Hours Rota Staffing (minimum 9 wte) and Funding

	WTE on rota	Funding stream	Funding balance/gap
Adult GPST	3	NES	-
Adult CT	1	NES when doctor in post	Up to 1.0 wte
MHOAS CT	1	NES	-
MHOAS FY2	1	NES	-
LD CT	1	NES	-
CAMHS CDF	1	Currently part-funded by senior time	1.0wte
BAS	1	NES when doctor in post	Up to 1.0 wte
Rehab CDF	1	MH Medical budget	-
Total (assuming all full time)	**10**		**+1 to -2.0**

2.3 Assessment

Junior/foundational support

1. Junior out-of-hours rota

Less-than-full-time (LTFT) working is now normal, rather than exceptional, for junior doctors. It will be seen later that expansion and future development of the 'middle-grade' doctor, taking advantage of the new Specialty Doctor (SD) contract, is recommended to build resilience into the medical staffing model and grow our own doctors to eligibility for the new Specialist Doctor role. That will necessitate a clearer distinction between the roles of the junior and middle-grade staff. The first recommendation therefore is to assume a headcount of 10 junior doctors will be required to staff the minimum 9 wte first-on-call rota.

As has been noted, there is established funding for 7 wte junior doctors. When Core Trainees (CTs) are allocated in the Borders Addictions Service (6-month tenancy) and in General Adult Psychiatry (GAP; 1 year tenancy, trial to commence August 2023) the funding will follow; it will not be allocated by NES if there is no trainee. Funding of the Clinical Development Fellow (CDF) input to CAMHS and contribution to the 'junior' out-of-hours rota is currently dependent on the medical staffing model including a junior doctor role; this is a 1-year trial but is recommended to become part of the establishment at a cost of **£95,000**. It is further recommended that 2 further doctors are recruited to fill gaps in the event there is no BAS or GAP CT. It is felt reasonable to assume that, in this worst-case scenario, less-than-full-time working across the group will offset this overspend by 1 wte.

The estimated maximum overspends (which is unlikely to be fully realised) is therefore **£190,000**. The 'best guess' is with LTFT working and NES funded doctors is that over 1-year extra costs are unlikely to exceed **£95,000.**

It is not possible to quantify overspends associated with NHS and agency locum fees for doctors filling gaps in the first-on-call rota. The above is therefore likely to be an overestimation of additional costs to the organisation of a resilient model.

2. Inpatients

Continual cover to the inpatient units is expected; demand to medical staff associated with this has steadily increased over time. In combination with the complexity and changes associated with the junior on-call rota, this has resulted in a significant organisational burden and affected the trainee experience. Calls frequently come from the adult inpatient unit directly to the consultant psychiatrist leading to stress and undermines our efforts to utilise consultant time where it adds most value. As part of prior papers, recommendations have been made to employ 3 permanent Physician Associates, one to cover each of the specialty inpatient areas. Funding for those has only been partially identified. 2 PAs were secured through interview: one is now in post in MHOAS, and another was due to start in East Brig in November 2023 but has since withdrawn. A CDF has been employed for one year to cover Huntlyburn; the start date of 2nd August 2023 was delayed. Due to the required expansion of junior time to fill the out-of-hours rota, cover to the inpatient units should become more robust. A PA would not be able to fulfil the range of duties needed in the out-of-hours setting. The current PA is supporting the current situation of depleted staffing in MHOAS however will not negate the need for the more robust medical cover outlined below. Once we move to that strategic stability position, the PA support may not be crucial to the sustainability of medical/support staffing.

BET have noted the current cost pressure relating to 1 PA in MHOAS**: £57,500**. In the event the PA leaves post, the need for replacement will be carefully considered, potentially saving that cost pressure. In the future event there is no GAP CT, it is recommended that a CDF is employed to cover Huntlyburn and contributes to the 'junior' out-of-hours rota.

<u>Senior Staffing by Service Area</u>

3. Learning Disability Service

This service is currently stable in terms of medical staffing though medical staff signal three issues: firstly they are managing Forensic LD cases with specific dedicated time but no specialist Forensic Psychiatry input (clinical and reputational risk); secondly there has been no recognition over time of the added expectation and demand of their time consequent to clinical, legal and other developments and, thirdly, the impact of the 'Coming Home' project. The 'Coming Home' project is a plan to bring home patients with the most complex needs associated with their Learning Disability currently residing in units across the UK. It will be a 12-bedded specialist unit within the Scottish Borders and has an estimated completion timescale of 2-3 years; it is likely to require an additional session of medical time to allow these most complex patients to access timely senior medical opinion. This will be considered as part of that project.

4. Rehabilitation Service

There is senior staffing resilience in the Rehabilitation Service after a prolonged period of deficit. Within that funding envelope however, time is being dedicated to the adult Neurodevelopmental agenda; an overall reduction in senior sessions is anticipated**.**

Table 4: Rehab Medical Staffing plan

	Consultant	Specialty Registrar/CDF	Specialty Doctor	Total (£)	Balance (£)
Establishment	1.5	1.0	0	335,000	-
Aug 23 – Feb 24	1.4*	1.0	0		
	£ 224,000	£95,000	-	319,000	16, 000
Future Scenario A	1.4	Up to 1.0	0		
	£224,000	£95,000	-	319, 000	16, 000
Future Scenario B^	0.9	Up to 1.0	0.8		
	£144,000	£95,000	£96,000	335,000	0

*NAIT funding included in adult

5. Liaison Service

This team is in early stages of development. Despite efforts on behalf of the Mental Health Clinical Board, the funding of the senior post is insecure. A total of 7 sessions are recurrently funded by Mental Health. 3 are funded on an 'ad hoc' and non-recurrent basis for example through past Action 15 funding underspends and currently the promise of funding via Unscheduled Care developments. It is very clear that 10 sessions are required to attract and retain consultant psychiatry in post and the organisation is obligated to either value and fund the service or accept the risk the current incumbent will not be retained due to continual shifting of priorities according to short-term funding streams rather than clinical priorities. The Mental Health service may also seek to utilise that resource to fill urgent gaps within core Mental Health services when needed. That latter situation, whilst a last resort, may prove to be necessary and represents a further risk to the sustainability of the post for the incumbent.

The strong recommendation is therefore that the wider organisation funds the remaining 3 sessions at a cost of **£48,000** in order to ring-fence this role and contribute to a robust foundational structure of consultant psychiatry.

6. Borders Addictions Service

The substantive consultant psychiatrist in Borders Addictions Service intends to move abroad early next year and is therefore due to resign from post imminently. He may be in a position to remain as NHS locum (cost neutral) for a further interim period. We are currently in talks with a senior trainee who may apply for the post and could take that up from between April and August 2024. It is unlikely she will undertake senior on-call duties; however, this is a further risk to the continuity of the senior rota which his already under threat. Assuming no other interest in the post, the best-case scenario is that we face up to 7 months of no psychiatrist or agency medical cover. It should be borne in mind that there will be no Borders Addictions Service Core Trainee from February 2024 due to the anticipated gap in senior cover. The service is also supported by a GP with a Special Interest who has recently resigned. Further planning is underway to mitigate clinical risk and estimate financial risk.

7. Mental Health of Older Adults Service

The Scottish Borders has a large and predicted to increase elderly population. Social and support services are stretched and those with higher-level needs are at greater risk of requiring medical care due to both complex comorbidity and local resource issues. Developments aimed at caring for older people at home often require senior clinical support to support quality and sustainability. NHS Borders closed 14 acute dementia care beds in 2019; investment in 'replacement' specialist care home capacity was inadequate. Two additional consultant sessions were provided to support the newly developed clinical team overseeing care homes. The remaining beds for older adults with acute and complex 'functional' psychiatric illness or dementia, totalling 18, are routinely 100%+ occupied, placing further demand on community services led by and dependent upon consultants. The range of consultant sessions represents total funding rather than ideal staffing models; in reality consultants have regularly and at short notice shifted areas of responsibility, models of medical staffing and care arrangements to adapt to a changing resource landscape. Continuous disruption to service continuity and job planning was instrumental in a substantive colleague leaving post in 2023.

There is currently an agency locum without CCT providing support to the service. Our plan includes a direct employment arrangement to reduce costs of his employment to the organisation and to support towards CCT (consultant credential) equivalent as a further governance assurance step. A minimum 'floor' of senior time is needed to supervise non-consultant doctors and to serve the senior functioning of the service overall; currently we are below this minimum. For one year there will be a Less Than Full Time (LTFT) senior trainee, providing a degree of support but requiring senior supervision. The plan is to advertise for a new Specialist Doctor to secure a more immediately resilient model, allowing us to 'grow' current SD doctors to eligibility for application for the Specialist grade. Both scenarios are represented below.

Table 5: MHOAS Medical Staffing Plan

	Cons	SD	Specialist Doctor	Total (£)	Balance (£)
Establishment	3.2	0	0	512,000	-
Contingency Plan A (development)	1.8	1.8	1.0		
	£288,000	£216,000	£127,000	631,000	(119,000)
Contingency Plan B (stability)	1.8	Up to 1.0	1.0		
	£288,000	£120,000	£127,000	535,000	(23,000)

8. Child and Adolescent Mental Health Service

The Child and Adolescent Mental Health Service is under pressure with extensive waits for initial assessment, and a growing number waiting a significant amount of time post-assessment for clinical intervention. Despite an increase in staffing secondary to government funding (Recovery and Renewal), the wider MDT staffing situation has recently been affected by maternity, other leave and resignations. Pressure to address the waits, increased referral rates and greater efficiency in some pathways has led to a higher level of clinical need being addressed within the teams. The recent loss of a 0.9 WTE consultant psychiatrist, and no suitable replacement, has focussed this increased responsibility on the fewer senior doctors. A model of added junior time is being trialled and, as with other services, additional support to consultants to maximise use of their time is sought. Despite this, pressure on the senior doctors is unsustainable and their clear recommendation is to replace the lost consultant time. It is recommended therefore that we immediately advertise for a Specialist Doctor and that we move towards an over-

established permanent SD complement in order to 'grow' towards that senior role if we are unsuccessful. As noted above, it is recommended the SR/CDF post become permanent in order to support the 'junior' on-call rota and provide at least some support meanwhile to senior doctors.

Table 7: CAMHS Medical Staffing Plan

	Cons	AS	Specialist Doctor	SR/CDF	SD	Total (£)	Balance (£)
Establishment	3.6	0.6	0	0	0	657,000	-
To Aug 24	2.9*	0.6	0	1.0	0.8		
	£464,000	£81,000	0	£95,000	£96,000	736,000	(79,000)
Contingency Plan A	2.7	0.6	1.0	1.0	0		
	£432,000	£81,000	£127,000	^	-	640,000	17,000
Contingency Plan B	2.7	0.6	0	1.0	Up to 1.6		
	£432,000	£81,000	-	^	£192,000	£705,000	(48,000)

*2 additional sessions funded through R&R underspends; 1 for additional leadership responsibilities and 1 for NDD pathway backlog

^The SR/CDF cost is counted in the junior establishment, see table 2

9. General Adult Psychiatry

The establishment of the 3 adult teams is 1.7 wte consultants each. In the South and East catchment this has translated to 1.2 wte consultants and support from Specialty Registrar or Specialty Doctor time, up to 1.0 wte. The adult consultants support Borders Crisis Team and have historically contributed proportionately the most to the second-on-call rota. With regard to BCT, specific and dedicated senior medical leadership is requested. The medical Personality Disorder lead, a 0.5 wte Specialty Doctor, is not included in the below table.

In order to move towards sustainability, it is recommended that there are SD doctors in each of the 3 teams, being actively developed and supported towards the new Specialist Doctor grade or though CESR to consultant level. In this way we will 'grow our own' capable and autonomous doctors who can actively contribute to the effective use of resource in our services, support the consultants to undertake the consultative role (including consideration of senior support to BCT) and provide a degree of stability and continuity if senior staff move on. The SD role will be undertaken by doctors at different developmental stages. It has been mentioned that a certain critical mass of consultant doctors is needed to deliver leadership across clinical and other areas. It is recommended therefore that the minimum number of consultants is 1.0 wte per adult team plus 4.0 Specialty Doctors or vice versa: 4 consultants (including the potential for a Specialist Doctor) and 3 SDs.

For simplicity, the complex temporary and subspecialty cover arrangements are not covered below. The middle grade and senior staffing across the 3 teams has been combined.

Table 8: GAP Medical Staffing Plan

	Cons	SD	Specialist Doctor	Total (£)	Balance (£)
Establishment	4.1	2.0	0	896,000	-
Contingency Plan A	3.0	3.0	1.0		
	£480,000	£360,000	£127,000	967,000	(71,000)*
Contingency Plan B	3.0	4.0	0		
	£480,000	£480,000	-	960,000	(64,000)
(Plan C)	4.0	3.0	0		
	£640,000	£360,000	-	1,000,000	(104,000)

*In the summary table, the Specialist Doctor option is costed as 'best guess' as we aim to grow SDs

10. Senior out-of-hours rota

In the above plans, the senior out-of-hours rota remains in a precarious state; these shifts are falling to fewer doctors to fulfil, albeit at an enhanced rate, and without recognition they contribute to exhaustion over time. It is recommended time off is added to locum shifts offered to substantive colleagues to ensure they are sustainable however impact on daytime activity (and cross-cover arrangements) must be considered.

11. Retention

As noted in the embedded paper, MHLD Consultant Staffing, there has been a recent exodus of experienced substantive consultant psychiatrists from NHS Borders Mental Health Services. As explained within that, many pressures on the profession are national and out with the direct control of NHS Borders. That being said, the issue facing NHS Borders prior to that was one of retention of existing staff. Recruitment to the service (with one exception: MHOAS) had been fairly successful, albeit achieved through a targeted and individualised approach to identifying and attracting senior staff. We need to learn from experience and use all levers locally available to support substantive doctors in our employment and address their concerns. A recent senior medical away day highlighted a number of issues currently being worked through by senior manager colleagues. Themes included: inadequate basic administrative support; disintegrated working; the role of the consultant within clinical teams and unclear decision-making and accountability structures. It is suggested that retention of existing staff goes hand in hand with successful recruitment, even in this challenging landscape, and should receive urgent attention. The final recommendation therefore is that NHS Borders Mental Health Service focus on retention of its residual medical workforce and, as an urgent measure, provide dedicated administrative support to all senior medical staff.

Summary

The current medical staffing situation within Mental Health and Learning Disability services are precarious. Further recommendations may result from work looking to retain senior staff and should be prioritised. Foundational support to senior doctors is required including adequate administrative support, robust cover to the 'junior' on-call rota and cover to the inpatient units. Almost half of additional costs in the 'worst case' position arise from the need for full cover to the first-on-call out-of-hours rota and does not meaningfully address the deficits in senior cover. The Liaison Psychiatry sessions represent a longstanding deficit but are added for completeness. Strategically, £57,500 for PA support may not be required in the long-term. Substantive senior doctors should be fully supported to fulfil added responsibilities falling to them to maintain core services and to ensure their leadership is contribution is actively facilitated.

Growth of the 'middle' grade is underway. These doctors can also be developed to include certain service-level leadership roles however this requires initial structural support which will rely on the consultants. This could be assisted by Specialist Doctors, and advert for those is recommended; in the interim agency consultant will be needed.

Table 9 below sets out a summary of the recommendations discussed within this paper. As can be seen we have 3 scenarios with our best guess cost to establish stability within the workforce and provide a more cost-effective staffing model than at present. The best guess scenario will require additional investment of £262k pa which will provide a reduction in the recurring cost pressure of £266k pa.

Table 9: Summary of Recommendations with Cost Implications

Recommendation number/type		Cost difference from current (Best Case)	Cost difference from current (Worst Case)	Best guess stability position
Junior				
1 & 2	SR/CDF	(95,000)	(190,000)	(95,000)
3	PA	0	(57,500)	0
Subtotal Junior		**(95,000)**	**(247,500)**	**(95,000)**
Senior				
-	Rehab cons session	16,000	0	16,000
4	Liaison cons sessions	(48,000)	(48,000)	(48,000)
5	MHOAS	(23,000)	(119,000)	(23,000)
6	CAMHS	17,000	(48,000)	(48,000)
7	GAP	(64,000)	(71,000)	(64,000)
Subtotal senior		**(102,000)**	**(270,000)**	**(167,000)**
Total Recommendation		**(197,000)**	**(533,500)**	**(262,000)**
***2021 medical staffing overspends**		**(528,168)**	**(528,168)**	**(528,168)**
Difference – Rec. vs 2021 overspend		**331,168**	**(5,332)**	**266,168**

*2021 chosen as 2022 was a year of relatively comfortable substantive senior staffing that is no longer achievable in the current climate

The following are recommendations that we are making to the NHS Borders Board, for consideration as part of the financial planning and payment to the Integration Joint Board as a delegated service:

RECOMMENDATIONS

1. Support the funding of a CDF/SR doctor in CAMHS at a cost of £95,000 to contribute to the first-on-call out-of-hours rota and support resilience to the CAMHS senior staffing.
2. Support the funding of the junior staffing to a 'headcount' of 10, which includes the doctor noted above and assumes an average 9 wte across the service. The additional cost of a further £95,000 will be offset by instances where both BAS and GAP CT1s are provided by the deanery with LTFT working across the group and costs incurred currently to fill out-of-hours gaps (unquantified).
3. Note the unfunded PA at a cost pressure of £57,500 which is supporting current deficits within MHOAS. If stability as per plan has been achieved, consider the need for replacement.
4. The organisation should close the 3-session funding gap for Liaison Psychiatry, at a cost of £48,000, allowing full focus of time to the General Hospital priorities and in order to retain the full-time consultant. It is the opinion of the Mental Health Board this should not be drawn from core Mental Health funding.
5. It is recommended a Specialist Doctor role is advertised in MHOAS which if successful could allow an SD to be moved to the adult service. If unsuccessful, further supports to the service will be necessary.
6. It is recommended that a Specialist Doctor role is advertised for CAMHS and if this is unsuccessful, additional SD time is sought to 'grow' towards the Specialist Doctor role, to a maximum of 1.6 wte.
7. It is recommended a Specialist Doctor role is advertised in GAP and that a model of 3 SD doctors supporting 4 consultants, or 4 SDs growing towards the Specialist Doctor role with the support of a minimum 3.0 wte consultants is adopted. As the adult service is currently below that floor, further short-term supports will be needed.
8. It is recommended that substantive consultants undertaking additional out-of-hours shifts should be offered time off (1 hour per additional weekday shift; 2 hours per weekend shift) in order to support wellbeing and sustainability. Cross cover and impacts on daytime activities should be monitored.
9. Previous recommendations have been made around retention of senior doctors within service including establishing adequate administrative support and re-establishing the consultant role as consultative and clinical leader of their teams; further recommendations may result from ongoing work in this area. Dedicated administrative support for all senior doctors should be expedited.

2.3.1 Quality/ Patient Care

The current position of medical staff overall shortages and the reliance to partly bridge that gap via agency Drs is inevitably having an impact upon patient care and quality of care. Taking the steps set out within this paper will improve patient care.

2.3.2 Workforce

.

A secondary impact of the shortages within the medical workforce is the negative impact this is having upon the remaining staffing establishment, both within the medical workforce and the wider team. This is leading to increased workloads, increased lists and waiting times. Further difficulties in recruitment and retention are anticipated along with negative impacts upon staff wellbeing. Taking the steps set out within this paper will improve recruitment, retention and workforce wellbeing. It will

also allow more opportunities for medical staff to progress to more senior positions leading to less reliance upon external recruitment - succession planning.

2.3.3 Financial

As set out within table 9 above, this medical staffing plan relies upon a best-case scenario additional investment of £262k pa. It should be noted that this could fluctuate between a range of £197k and £533k p. The best-case scenario investment of £262k pa will reduce the average cost pressures of £528k pa by £266k pa.

2.3.4 Risk Assessment/Management

The risks related to this workforce plan are largely centred around our ability to recruit to it. Mitigations within the plan include the range of options we have set out in the individual contingency plans whereby we have a range of grades to recruit to.

2.3.5 Equality and Diversity, including health inequalities.

An impact assessment has not been completed as this is not a change in service delivery.

2.3.6 Climate Change

None.

2.3.7 Other impacts

None.

2.3.8 Communication, involvement, engagement and consultation

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

State how his has been carried out and note any meetings that have taken place. We believe that forma stakeholder engagement is not required as this plan is regarding recruitment and retention challenges rather than a change in operational delivery. However, we have engaged with:

- Senior Leadership teams within Mental Health Services
- Mental Health Senior Leadership Team
- Operational Delivery Group NHS Borders

2.3.9 Route to the Meeting

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

- Operational Planning Group NHS Borders
- NHS Borders Executive Team

2.4 Recommendation

- **Decision** – Board members are asked to consider their level of appetite to support this, which will be used to inform the payment offer from NHS Borders to the Integration Joint Board.

3 List of appendices

N/A

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Resources & Performance Committee Minutes**
Responsible Executive/Non-Executive:	**Ralph Roberts, Chief Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Resources and Performance Committee with the Board.

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Resources & Performance Committee 2 November 2023

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Resources & Performance Committee minutes 07.09.23

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 7 September 2023 at 9.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Non Executive
Mrs L O'Leary, Non Executive
Ms S Lam, Non Executive
Mr J Ayling, Non Executive
Cllr D Parker, Non Executive
Dr K Buchan, Non Executive
Mr J McLaren, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Dr S Bhatti, Director of Public Health
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Mr A Carter, Director of HR
Mr C Myers, Chief Officer, Health & Social Care
Mrs L Jones, Director of Quality & Improvement

In Attendance:
Miss Iris Bishop, Board Secretary
Mrs S Errington, Head of Planning & Performance
Mr B Joshi, General Manager Unscheduled Care
Mr K Lakie, General Manager Planned Care
Mrs C Oliver, Head of Communications
Ms S Laurie, Senior Communications Officer

1. Apologies and Announcements

1.1 Apologies had been received from Mrs H Campbell, Non Executive, Mr T Taylor, Non Executive, Mrs J Smyth, Director of Planning & Performance and Mr G Clinkscale, Director of Acute Services.

1.2 The Chair welcomed Mrs Steph Errington, Head of Planning & Performance who deputised for Mrs Smyth.

1.3 The Chair welcomed Mr B Joshi, General Manager Unscheduled Care and Mr K Lakie, General Manager Planned Care.

1.4 The Chair confirmed the meeting was quorate.

2. Declarations of Interest

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted there were none declared.

3. Minutes of Previous Meeting

3.1 The minutes of the extraordinary meeting of the Resources and Performance Committee held on 17 August 2023 were approved.

4. Matters Arising

4.1 **Action 2023-6:** Mr Ralph Roberts advised that he had been unable to meet with Mrs Jones due to other pressures and consequently the action currently remained ongoing.

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

5. Performance Scorecard

5.1 Mrs Steph Errington provided a brief overview of the content of the report and highlighted that the report set out performance as at the end of July against the targets approved in the Annual Delivery Plan. There were several measures that had not been achieved and mitigating actions had been put in place. She also drew the attention of the Committee to the challenges being experienced in the acute mental health team and the remedial actions that were put in place.

5.2 Mr Chris Myers highlighted the challenges both in the adult mental health service and the child and adolescent mental health service (CAMHS) which were exacerbated by staff absences, and a number of vacancies that were difficult to recruit to as well as adult psychiatrist vacancies. Discussions had been held to look at stabilisation and sustainability of services. In the short term referrals would continue to be accepted, staffing mix and skill mix would be explored and a 6 week wait would be introduced for non urgent cases to enable services to reconfigure.

5.3 Mrs Fiona Sandford noted that the shortage of psychiatrists was UK wide and she enquired if the Royal Colleges were addressing the issue. Dr Lynn McCallum commented that there was awareness of the shortage nationally and the Royal Colleges were working with the Scottish Government to change the consultant role to a more overview type role with less patient facing activity and enabling other mental health staff to work alongside consultants.

5.4 Mr James Ayling sought assurance that any risks to patients were being addressed. Dr McCallum commented that the 6 week pause was only for routine work and assured Mr Ayling that all emergency and urgent work would continue to be addressed.

5.5. Dr Sohail Bhatti commented that in Lancashire a redesign had enabled associates to undertake the lower level elements of the pathway and ensure consultants as the experts oversaw the work. Dr McCallum commented that the purpose of the 6 week pause was to enable the service to redesign and reprioritise caseloads and establish who should be where and when and who would be doing what to make it as equitable as possible.

5.6 Dr Kevin Buchan commented that his primary care colleagues would be supportive of a redesign as it had been clear for some time that mental health teams were under pressure and to allow them to refocus for a period of 6 weeks would be helpful.

5.7 Mrs Sandford enquired about the actions undertaken to protect elective surgery and also if the national centres of treatment were established and being accessed.

5.8 Mr Ralph Roberts commented that in terms of the national treatment centres (NTCs), they had been developed as a set of individual schemes to address capacity issues in certain parts of the country and had been wrapped up into NTCs. NHS Borders did not have immediate access to the NCTs as at the time they were developed the organisation was in a better position than other Health Boards and did not envisage a need to utilise them. He advised that there was an ambition to coordinate and balance waiting lists across the country so that areas were not disadvantaged.

5.9 Ms Sonya Lam enquired about the Boards strategy in terms of the agenda and how the public could access services further upstream.

5.10 The Chair sought assurance that people were sign posted in the short term to other services such as chaplains, pastoral care, etc whilst they had a slighted extended wait for a mental health appointment.

5.11 The Chair also commented that the delayed discharges statistics continued to increase.

The **RESOURCES & PERFORMANCE COMMITTEE** noted performance as at the end of July 2023.

6. Finance Report

6.1 Mr Andrew Bone provided an overview of the content of the report and highlighted several key elements including: £9.33m overspend to date; Q1 review remained the forecast at end of year of £26m; at month 3 the direction of travel was a £30m overspend, actions were undertaken and at month 4 the position had improved slightly; savings had been achieved in June and July and about £1m of progress had been made; 3 big risks had been identified of GP prescribing, winter, and unpredictable hight cost/low volume; mitigation of cost pressures; enhanced grip and control; and identifying additional savings.

6.2 Mr Bone then provided a short presentation to enable discussion of the issues within the report.

6.3 Discussion focused on: budget ownership and management workshops; potential to have an addendum to put the 3 year plan into perspective in terms of accumulative brokerage; timetable to be produced of what to be delivered by when against the diagnosis report 11 actions; work is on going on the strategic plan for the Borders General Hospital and may have a an outline by March to set the direction but not a fully worked up plan; value based health care; prioritise according to need; unable to provide infinite care with finite resources; collaboration with the Integration Joint Board to achieve major savings and transformation; within value base medicine the evidence suggests that 20% of what we do has no value to the patient; drug costs are increasing; clinicians are very much engaged in value based medicine; time lag in prescription costs and the change in system at National Services Scotland; patients are encouraged to medicalise their conditions and it is hard for clinicians to de-medicalise the issue when the patient is determined it is a medical issue; a patient consultation will take 40 minutes to get the patient to accept the issue is not medical; and there is a fundamental need to de-medicalise society as a whole.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the Board was reporting an overspend of £9.33m for four months to end of July 2023.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the position reported in relation to recurring savings delivered year to date.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the updated outturn position of £26.1m following completion of the Q1 review, and that that represented a deterioration from the financial plan submitted in March 2023 which forecast a deficit of £22.5m.

The **RESOURCES & PERFORMANCE COMMITTEE** noted plans were being prepared and discussed to address the deterioration in the forecast outturn.

7. Capital Plan Update

7.1 Mr Andrew Bone provided an overview of the capital plan and drew the attention of the Board to the endoscopy decontamination and CT replacement, both of which were on track for delivery. A number of other projects were being progressed, however the aseptic unit and adult changing facility remained as projects that were not yet resourced.

7.2 Cllr David Parker welcomed the progress being made, however he remained concerned that the adult changing facility had not been progressed.

7.3 Mr Bone commented that a rapid feasibility study had been commissioned in regard to the adult changing facility and 2 options within the Hospital had already been identified. Both options had challenges however the outcome of the feasibility study had not concluded. He was confident that a solution would be identified with an expectation of moving to the procurement stage and a facility being in place by the summer of 2024.

7.4 Mr Ralph Roberts drew the attention of the Board to the reference to LIMS within the paper and advised that whilst the project had been expected to be delivered by October 2023 it had been delayed and completion was now expected by February 2024.

7.5 Mr James Ayling enquired about the possibility of a revenue resource project to be moved elsewhere. Mr Bone commented that the conversations took place with the Scottish Government in January to March each year to find potential solutions for both parties in order to maximise the use of the capital budget.

7.6 In terms of RAAC, Mr Bone provided an update to the Board and highlighted that the national desk top exercise had been undertaken and identified several buildings that had the potential to have RAAC present in the building. The national survey project was progressing and expected to conclude by the end of October. Mr Bone suggested there were 4 buildings that were likely to contain RAAC and that detail had been shared with NHS Assure and the national survey programme were identifying surveyors to survey he facilities the following week. Communications were being developed for the public and an initial incident management group would be set up.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the update provided in the paper and recognised the risk in relation to slippage on the programme and the actions in place to mitigate the risk, including further dialogue with Scottish Government.

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

The **RESOURCES & PERFORMANCE COMMITTEE** noted the update on the LIMS project and asked that it be included on the Action Tracker to ensure delivery by February 2024.

8. Property Asset Management Strategy

8.1 Mr Andrew Bone provided a presentation on developing the property strategy and highlighted several key elements.

8.2 Mr Ralph Roberts commented that it was an ambitious piece of work and would need to link to the clinical strategy taking cognisance of the sustainability of services and future workforce recruitment, as well as the totality of cost from a capital perspective.

8.3 Ms Sonya Lam commented that the modelling would take time and the timescale for the strategy did not provide that. She suggested there would need to be a strategy to wrap around the model of care of what the population needed, the workforce available and the digital ability. She enquired if support was required to bring that transformation to fruition.

8.4 Mr James Ayling commented that it was a really good catalyst and starting point and he welcomed it.

8.5 Mr Bone explained that capacity and capability were always challenging and the initial plan was to use NHS Assure expertise to draw up an initial assessment and provide an understanding of what was wrong, as what was being highlighted by staff was that they believed they required more or better space in order to deliver their services efficiently. Mr Bone further emphasised that when planning a large hospital project it was not the building that was planned but the services to be provided and at the same time it had to be a parallel process and the scale of healthcare planning attached to large hospital projects was significant.

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

9. Surge Planning

9.1 Mr Chris Myers provided a presentation on the current situation in regards to surge planning including: outlining the principles of what we are doing and the objectives; the process being followed; delayed discharge trajectory assumptions; additional community capacity; surge closure plan options 1 and 2; financial costings for both options remained the same; quality and performance impacts of options 1 and 2; and strategic and operational risks.

9.2 Discussion focused on each option and several questions were asked including: were there any staffing implications across either option?; if prioritising scheduled care would there be one ward ringfenced entirely for elective surgery?; do we currently favour unplanned care and that would be our priority; was there any information from NHS Forth Valley that might help with decision making on this matter?; what impact of resource in terms of current staffing recruitment had on either option?; and consideration needed to be given to potential increased in delayed discharges meaning level of need would also increase.

9.3 Mr Myers confirmed that in terms of staffing both options had the same level of staffing impact and the costs were the same.

9.4 Mr Bhav Joshi commented that in terms of favouring unplanned care, option 2 did not assume a ringfenced ward for electives, the elective programme would be delivered through wards 7 and 9.

9.5 Dr Lynn McCallum commented that in terms of unscheduled care versus planned care, unscheduled care was prioritised for purposes of flow as patients were acutely unwell. As the elective programme was being reduced it was becoming evident that people were becoming more acutely unwell and they were not receiving the interventions they needed at the time they needed them. Most people were manageable at home. NHS Forth Valley had maintained their elective programme and were the worst performing Board in Scotland for the A&E performance standard.

9.6 Mrs Lucy O'Leary suggested the Board needed to understand the risk it was asking clinicians to live with and enquired in terms of inequalities who the Board was potentially being inequitable and harmful to.

9.7 Mr Ralph Roberts commented that in regard to risk it was not quantifiable in how decisions were made in the short term. He suggested the Board needed to be clear in the financial plan of the cost of what was expected to contribute to the outturn position including an assumption of surge beds being opened and a choice to close surge beds over a period of time. Mr Roberts further suggested that the Board should progress matters in the order suggested under Option 1 to improve unscheduled care performance as there was a level of risk that was unacceptable as well as pressures on staff in that part of the system that required to be alleviated. He suggested that the planned care piece should follow on quickly as the next stage in the process.

9.8 Further discussion focused on: staff engagement and their views; original purpose of Blue ED; diluted efficacy on AHP involvement; grip and control present around any decisions and safeguards to ensure where a decision is taken to surge the impact on finance and staffing resources are controlled; thresholds for opening surge would be in place based on data showing demand increasing beyond the plan; closing Blue ED is the first thing to do to remobilise electives; need to be clear on the triggers and prioritise the performance piece in a balanced way over and above not opening beds due to finances; unscheduled care, planned care and delayed discharges are all joined together and need to be addressed collectively; how can we support our clinical colleagues to make difficult decisions; the front should not be open unless there is an urgent acute medical need; to survive winter and get into financial balance there will have to be difficult decisions made; and the Board needs to provide air cover to clinicians.

9.9 In summary Mr Roberts confirmed that the Board appeared to be supportive of Option 1, and he reiterated that finance would not be prioritised to the extent of everything else in the short term. He suggested commencing with Option 1 to release unscheduled care pressure and to then describe in more detail the next steps and if possible include more quantifiable data on harm. He also suggested including the work being undertaken on values based healthcare so that it could be seen in the round by the Board and the public .

The **RESOURCES & PERFORMANCE COMMITTEE** noted the presentation and agreed to support Option 1.

10. Any Other Business

10.1 Mr Ralph Roberts recorded that a letter had been received from the Scottish Government in regard to assurance mechanisms linked to the Lucy Letby case. A response was being drawn together and assurance mechanisms would be picked up through the Boards governance processes.

11. Date and Time of Next Meeting

11.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 2 November 2023 at 9.00am via MS Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Endowment Fund Board of Trustees Minutes**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Endowment Fund Board of Trustees with the Board.

2.2 Background

The minutes are presented to the Board as per the Endowment Fund Board of Trustees Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board as per the Endowment Fund Board of Trustees Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Endowment Fund Board of Trustees 4 October 2023

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Endowment Fund Board of Trustees minutes 07.08.23

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 7th August 2023 @ 11 a.m. via Microsoft Teams.

Present: Mr J Ayling, Trustee
Dr S Bhatti, Trustee
Mr A Bone, Trustee
Mrs K Hamilton, Trustee (Chair)
Mrs S Horan, Trustee
Mrs S Lam, Trustee
Mr J McLaren, Trustee
Cllr D Parker, Trustee
Mrs F Sandford, Trustee

In Attendance: Ms C Barlow, Charity Development Manager
Ms F Haro, External Auditor, Thomson Cooper
Mrs S Swan, Deputy Director of Finance (Head of Finance)
Mrs K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Apologies had been received from Mr R Roberts, Trustee, Dr L McCallum, Trustee, Mrs H Campbell, Trustee, Mrs L O'Leary, Trustee and Mrs J Smyth, Director of Planning and Performance.

2. **Declaration of Interests**

There were no declarations of interest.

3. **Minutes of Previous Meeting : 15th May 2023**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker

The action tracker was noted.

5. **Endowment Fund Annual Accounts 2022/23**

5.1 *Final 2022/23 Report from Trustees and Annual Accounts*
Susan Swan introduced this item and highlighted the report circulated detailed all changes made to the annual report and accounts following the meeting held on the 15th May 2023. It was noted that any comments received following this had also been taken into account. Susan advised that the first main adjustment within the accounts related to the inclusion of a legacy from E Macmillan which was receipted in May and totalled £110,446. It was noted that at the point of the draft report and accounts this legacy had been included as a contingent asset as the sum had not been confirmed/received, however this had now been moved under income received. Susan went on to explain that the second main change to the accounts was linked to the movement of the Charity's for All award, which actually related to 2023/24 expenditure so had been moved to deferred income. It was

noted that this had been recorded as income within the draft version of the accounts.

Fiona Haro commented that it had been a very efficient audit with no issues arising, therefore a clean opinion had been issued.

James Ayling referred to the E Macmillan legacy and asked for confirmation that this had now been received. Susan confirmed that it had been.

Susan went on to ask if there were any queries from Trustees on the Annual Report and Accounts document which was being recommended to go forward to Borders NHS Board for approval. James highlighted reference within the External Audit report recommending that movement within the investment portfolio is reviewed and updated to the date on which the accounts are approved and asked if reference was required to be made within the annual report and accounts in regard to this. Susan advised that this information had been received from Investec on Friday (4th August) and as the overall movement within the fund was £40,000 it was not proposed any adjustment be made as it was not of significant value.

Susan asked Karen Hamilton, as Chair of the Board of Trustees, if she would be content signing the letter of representation, on behalf of the Trustees, confirming that all relevant disclosures had been made and there were no further issues which the auditors required to be made aware of. Karen confirmed that she would be content to do this following the meeting.

The Board of Trustees approved the 2022/23 Report from Trustees and Annual Accounts.

5.2 *Audit Completion Report*

Susan Swan spoke to this item which detailed the recommendations made by Thomson Cooper, External Audit, following the audit. Susan highlighted the recommendation regarding the negative funds which had been discussed at the previous meeting in May and confirmed that there would be a report coming forward on this. Susan also advised that she would be working with the Fundraising Team about putting a referencing system in place for donations to ensure completeness.

Fiona Haro added that clarification was required in terms of the wording in regard to restricted and unrestricted funds and confirmed that there is ongoing dialogue around this.

James referred to the failure to have numerically referenced details of the donations made within wards, and although he was aware this had been picked up and would be resolved, he asked External Audit if they felt there was a reasonable process in place for the detection of fraud or if their audit was sufficient to provide Trustees with that reassurance. Fiona felt that at the high level at which they were looking there was sufficient controls and procedures in place and they could detect fraud under the terms of the testing undertaken. Fiona appreciated that in regard to donations made on wards it could be difficult obtaining signatures so it was trying to get something in place which was both practical and give assurance to Trustees.

James also enquired if there was anything undertaken by other organisations of a similar size which may be appropriate for the charity to adopt. Fiona felt that most are doing something similar, however highlighted that post Covid there would be merit in revisiting the Financial Operational Procedures to ensure that these are amended alongside any changes to working practices.

Susan confirmed that she would arrange for the annual report and accounts to be signed and returned for signature by Thomson Cooper. These would then be available for circulation after the NHS Borders Board meeting on the 17th August 2023.

The Board of Trustees noted the audit completion report.

6. **Any Other Business**

Staff Lottery Fund
John McLaren advised that he would be bringing forward a paper on the Staff Lottery Fund to the next Endowment Fund Board of Trustees meeting. John explained that the paper would be asking Trustees for a decision on the Staff Lottery Fund, which currently sits as an Endowment Fund, but has a different purpose in the sense that money is collected specifically from staff and has been increasing over the years as it is not being spent. The question which would be posed to Trustees is whether this is now managed by the organisation, in which case it would probably fall within the remit of the Staff Wellbeing Group, or remain as an Endowment Fund but getting a separate criteria so that it could be used on staff directly. It was noted that following a decision by Trustees consideration would be given about using these funds to give staff small financial rewards for long service. This would be discussed in more detail with the Board Executive Team and proposals would be included within the paper presented to Trustees.

Margaret Kerr Unit Endowment Fund
Karen Hamilton advised that under the existing levels of authority the Director of Finance, Chief Executive and herself had approved an Endowment Fund request from the Margaret Kerr Unit for a research fellow to look at some research duties within palliative care. Karen noted that this was appropriate within the current process but it had led them to consider that due to the significant fund sitting within the Margaret Kerr Unit there would be merit in setting up a small sub group to look at how to make best use of this fund.

Andrew added that for this particular example in which the delegated powers had been used it was a relatively small amount in terms of the value. Andrew felt that these powers were essentially intended for exceptional use rather than everyday use and in terms of funds management, since the Lead for Palliative Care had left the organisation, there had not been an understanding on how this fund was going to be deployed. Andrew felt that if Trustees were serious about promoting the spend of funds, and to direct the strategic direction as to how funds are used to best effect, there was a need to set up a group which would be chaired by a Trustee and would include representation from appropriate stakeholders.

Due to the value of the fund Andrew suggested that this be run independently to the Endowment Advisory Group, which is the normal route for bringing forward funding

requests, or to the Board of Trustees due to the volume of decisions which theoretically could start to be made through the sub group. Andrew felt it would be beneficial to put this structure in place as he did not feel that the existing structure met the needs of this fund.

It was noted that there would be further discussion at the next Endowment Fund Board of Trustees meeting.

7. **Date and Time of Next Meeting**

Wednesday, 4th October 2023 @ 2 p.m.

BE
31.08.23

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Finance Report – October 2023**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Senior Finance Manager**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Effective

2 Report summary

2.1 Situation

The report describes the financial performance of NHS Borders and any issues arising.

2.2 Background

NHS Health Boards operate within the Scottish Government (SG) Financial Performance Framework. This framework lays out the requirements for submission of Financial Performance Reports (FPR) to SG which include comparison of year to date performance against plan with full review of outturn forecast undertaken on a periodic basis (i.e. both monthly and through formal quarterly reviews).

NHS Borders has determined that regular finance reports should be prepared in line with the SG framework (i.e. monthly).

The board has remitted the Resources & Performance committee to "review action (proposed or underway) to ensure that the Board achieves financial balance in line with its statutory requirements".

The board continues to receive regular finance reports for reporting periods where there is no scheduled committee meeting.

2.3 Assessment

2.3.1 Quality/ Patient Care

Any issues related to this topic are provided as background to the financial performance report and it is expected that, where relevant, these issues will be raised through the relevant reporting line.

2.3.2 Workforce

Any issues related to this topic are provided as background to the financial performance report and it is expected that, where relevant, these issues will be raised through the relevant reporting line.

2.3.3 Financial

The report is intended to provide briefing on year to date and anticipated financial performance within the current financial year.

No decisions are required in relation to the report and any implications for the use of resources will be covered through separate paper where required.

2.3.4 Risk Assessment/Management

The paper includes discussion on financial risks where these relate to *in year* financial performance against plan. Long term financial risk is considered through the board's Financial Planning framework and is not relevant to this report.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because the report is presented for awareness and does not include recommendation for future actions.

2.3.6 Climate Change

There are no climate change impacts identified in relation to the matters discussed in this paper.

2.3.7 Other impacts

There are no other relevant impacts identified in relation to the matters discussed in this paper.

2.3.8 Communication, involvement, engagement and consultation

Not Relevant. This report is presented for monitoring purposes only.

2.3.9 Route to the Meeting

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

- Senior Finance Team, 14th November 2023
- Board Executive Team, 5th December 2023

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Finance Report for the period to end October 2023

FINANCE REPORT FOR THE PERIOD TO THE END OF OCTOBER 2023

1 Purpose of Report

1.1 The purpose of the report is to provide committee members with an update in respect of the board's financial performance (revenue) for the period to end of October 2023.

2 Recommendations

2.1 Committee Members are asked to:

2.1.1 **Note** that the board is reporting an overspend of £15.36m for seven months to end of October 2023.

2.1.2 **Note** the position against the revised Q2 forecast outturn of £22.511m at year end, and the risks to achieving that outcome.

2.1.3 **Note** the position reported in relation to recurring savings delivered year to date (Section 5).

3 Summary Financial Performance

3.1 The board's financial performance as at 31st October 2023 is an overspend of £15.36m. This position is summarised in Table 1, below.

Table 1 – Financial Performance for seven months to end October 2023

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Revenue Income	300.90	327.72	189.75	189.45	(0.30)
Revenue Expenditure	300.90	327.72	178.53	193.59	(15.06)
Surplus/(Deficit)	**0.00**	**0.00**	**(11.22)**	**4.14**	**(15.36)**

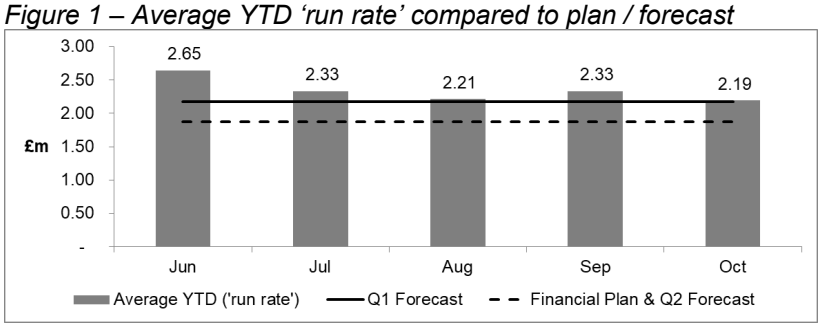
3.2 As part of the Q2 review the outturn forecast (as at March 2024) was amended to £22.511m deficit, in line with Board's Financial Plan.

3.3 The revised forecast is predicated on extrapolation of current trend on a number of areas of financial pressure (e.g. GP prescribing) which remain subject to variation and which therefore present a risk to the forecast.

3.4 Figure 1 provides an updated 'run rate' against forecast[1].

[1] Run Rate is calculated as the average monthly variance against budget (i.e. Year to Date variance divided by the number of months)

Figure 1 – Average YTD 'run rate' compared to plan / forecast



3.5 The YTD reported position of £15.36m overspend is £2.23m adverse against the revised Q2 forecast[2]. This is based on a 'straight line' (i.e. 7/12ths of forecast) assessment.

3.6 Actions are in place to deliver the improvement required during the period November to March which will achieve the forecast outturn, subject to any further variation in core operational performance. These actions include assumed benefit derived from release of accrued charges not yet realised in the year to date position; further grip & control actions as approved at the FIP board during October.

3.7 The forecast outturn will continue to be reviewed on a monthly basis with amendment for any significant changes to key variables.

3.8 Drivers for cost pressures are reported in section 4, below.

4 Financial Performance – Budget Heading Analysis

4.1 Income

4.1.1 Table 2 presents analysis of the board's income position at end October 2023.

Table 2 – Income by Category, year to date October 2023/2024

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Income Analysis					
SGHSCD Allocation	271.27	303.84	175.99	175.99	-
SGHSCD Anticipated Allocations	9.46	0.57	-	-	-
Family Health Services	10.24	12.66	8.39	8.39	-
External Healthcare Purchasers	4.68	4.68	2.78	2.45	(0.33)
Other Income	5.25	5.97	2.59	2.62	0.03
Total Income	**300.90**	**327.72**	**189.75**	**189.45**	**(0.30)**

4.1.2 As reported previously, the shortfall in income is related to a reduction in levels of activity through the Northumberland SLA. This shortfall reflects a reduction in activity against the contract baseline, which represents pre-pandemic activity levels.

4.1.3 It is likely that the commissioning body (Northumbria) will reduce the base activity level for future years and the impact of this adjustment will be reflected in the draft financial plan for 2024/25.

[2] Q2 review YTD position is calculated as 7/12's of £22.5m, i.e. £13.1m.

4.2 Operational performance by business unit

4.2.1 Table 3 describes the financial performance by business unit at October 2023.

Table 3 – Operational performance by business unit, October 2023

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Operational Budgets - Business Units					
Acute Services	69.07	82.07	46.94	46.79	0.15
Acute Services - Savings Target	(1.54)	(0.85)	(0.49)	-	(0.49)
TOTAL Acute Services	**67.53**	**81.22**	**46.45**	**46.79**	**(0.34)**
Set Aside Budgets	28.81	32.87	19.22	20.77	(1.55)
Set Aside Savings	(0.94)	(0.94)	(0.55)	-	(0.55)
TOTAL Set Aside budgets	**27.87**	**31.93**	**18.67**	**20.77**	**(2.10)**
IJB Delegated Functions	125.82	148.67	86.70	88.47	(1.77)
IJB – Savings	(4.33)	(3.84)	(2.24)	-	(2.24)
TOTAL IJB Delegated	**121.49**	**144.83**	**84.46**	**88.47**	**(4.01)**
Corporate Directorates	38.84	48.60	27.20	28.45	(1.25)
Corporate Directorates Savings	(0.05)	(0.54)	(0.32)	-	(0.32)
TOTAL Corporate Services	**38.79**	**48.06**	**26.88**	**28.45**	**(1.57)**
External Healthcare Providers	31.88	34.67	19.90	19.30	0.60
External Healthcare Savings	(0.13)	-	-	-	-
TOTAL External Healthcare	**31.75**	**34.67**	**19.90**	**19.30**	**0.60**
Board Wide					
Depreciation	5.06	5.06	2.95	2.95	-
Year-end Adjustments	-	(12.98)	(13.14)	(13.14)	-
Planned expenditure yet to be allocated	19.74	12.52	2.63	-	2.63
Financial Recurring Deficit (Balance)	(11.33)	(18.79)	(10.96)	-	(10.96)
Financial Non-Recurring Deficit (Balance)	-	(1.30)	(0.76)	-	(0.76)
Board Flexibility	-	2.50	1.46	-	1.46
Total Expenditure	**300.90**	**327.72**	**178.53**	**193.59**	**(15.06)**

4.2.2 **Acute Overall**[3]. The position is £2.44m overspent, of which £1.04m relates to non-delivery of savings.

4.2.3 Key drivers of operational cost pressures remain as per previous reports. This includes: on-going use of premium rate nursing and medical agency (with offset against core vacancies); unfunded inpatients beds; and medicines expenditure.

4.2.4 **Acute services** (excluding Set Aside) are reporting a net overspend of £0.34m. The main driver for this over spend is unmet savings which are being offset by continued underspend in pays, mainly related to vacant posts within Nursing & Midwifery. Vacancies are however utilised to offset workforce pressures across Set Aside (see below).

4.2.5 **Set Aside.** The set aside budget is overall £2.10m overspent, of which £0.55m relates to non-delivery of savings.

[3] Budget reporting is categorised as 'Acute Services' covering health board retained functions including planned care and women & children's services, and 'Set Aside' representing unscheduled care functions under strategic direction of the Scottish Borders IJB.

4.2.6 There continue to be significant financial pressures in relation to urgent & unscheduled care, aligned to areas of operational pressure. This includes additional staffing to support A&E resilience and out of hours provision (including 'blue ED' and overnight waits); and continued use of unfunded beds through the Borders View ward and additional boarding across the BGH site. As at October 2023 there were 22 unfunded beds open within BGH (including 7 MAU beds) and an average of 8-10 patients requiring overnight trolley stays within A&E.

4.2.7 In addition to unscheduled care pressures the Set Aside budget is also impacted by increased hospital prescribing, with overspend in Neurology against high cost medicines.

4.2.8 **IJB Delegated[4].** Excluding non-delivery of savings the HSCP functions delegated to the IJB are reporting an over spend on core budgets of £1.77m. This position is underpinned by a level of on-going vacancy across services which partly offset the cost pressures noted below.

4.2.9 Within Mental Health and Learning Disabilities the main drivers for overspend are the continued use of medical locums (agency) to address significant workforce gaps across consultant staffing (Mental Health); increases to the number and cost of individual packages of care for Learning Disabilities out of area placements. In addition, there is an increased pressure on Mental Health prescribing budgets.

4.2.10 Within Primary & Community Services there continues to be a significant pressure on GP prescribing budgets (see below) as well as a shortfall on funding available to support the current Vaccination Programme.

4.2.11 **GP Prescribing** - as at M07 the reported overspend is £1.18m. This position remains uncertain given disruption to normal reporting timescales for primary care prescribing. Current spend is based on estimates reflective of trends in expenditure to May 2023 and in volumes to June 2023. The issues related to GP prescribing data were described in further detail within the August report.

4.2.12 **Corporate Directorates** are reporting a net over spend of £1.57m on core budgets. This position is largely within Estates & Facilities, with key areas of financial pressure in relation to patient travel (supporting hospital discharge), utilities costs, and additional maintenance expenditure. Actions available to address these pressures are being considered through the Q2 review.

4.2.13 **External Healthcare Providers.** Excluding savings there is an underspend of £0.60m. Most areas are reporting underspends as at M07 with these underspends linked to reduced activity or historic averages. At present this is assumed to be non-recurrent and up to date activity has yet to receive in a number of areas. Scottish UNPACS is overspending due to increases in stem cell and cardiology patients treated within NHS Lothian earlier in the year.

[4] IJB Delegated functions are comprised of clinical board business units for Mental Health & Learning Disabilities and Primary Care & Community Services, including AHPs.

5 Savings Delivery

5.1 Table 4 shows the recurring savings targets allocated to each area and the full year achievement of those targets to date.

Table 4 – summary recurring savings achieved as at October 2023

	Recurring Savings Target £m	FIP Schemes identified – current year impact £m	Recurring Savings Achieved £m	Balance of Savings not yet delivered £m
Acute Services	(1.05)	*1.07*	0.67	(0.38)
Set Aside	(1.08)		-	(1.08)
IJB Directed Services	(1.06)	0.95	0.45	(0.61)
Corporate Directorates	(0.85)	0.44	0.13	(0.73)
External Healthcare Providers	(0.35)	0.35	0.35	-
Board Wide	(2.18)	0.33	0.22	(1.96)
Total NHS Costs	**(6.58)**	**3.15**	**1.83**	**(4.75)**

5.2 Recurring savings targets for 2023/24 were set at 2% plus the balance of savings not achieved against the 2022/23 target on an individual business unit level. Board wide savings relate to targets set against the Prescribing workstream.

5.3 The Financial Plan assumed a minimum delivery of £5m (i.e. 2% of base budget), against which there are recurring schemes identified totalling £3.6m, of which £3.15m is expected to be released during 2023/24.

5.4 As at October 2023, £1.83m has been transacted against budgets. This is in line with the expected profile of savings delivery against the schemes identified to date.

5.5 There is a balance of £4.75m remaining to be achieved against the total budget target, of which £3.17m would be required in order to achieve the position identified in the financial plan. Of this, only £1.32m is identified within current year plans (£1.79m full year effect).

5.6 Key risks to the FIP programme remain consistent with those outlined in the recovery plan, i.e. constraints on operational management capacity and analytical resources, and a dependency upon effective clinical engagement. Of these the most significant remains the demands placed upon operational management capacity due to whole system (operational) pressures.

5.7 Additional actions for further improvement, both recurring and non-recurring, are being considered through the FIP Board meetings. The next FIP Board meeting is scheduled for 5th December 2023.

6 Quarter Two Review

6.1 As previously reported, the Board's Q2 review was submitted to Scottish Government at end October 2023. This review described a forecast position in line with the Health Board's financial plan for 2023/24 (i.e. forecast outturn of £22.5m deficit).

6.2 This forecast presented an improvement on the position described at Q1 review (£26.1m deficit) however the improvement still represents deterioration on actual expenditure from plan given the additional funding (£4.7m) received in Q1 which is not reflected in the plan.

6.3 A meeting to review the Q2 forecast was held with Scottish Government colleagues on 9th November 2023. Formal feedback from this review is anticipated by end November.

7 Key Risks

7.1 Financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 3588). This risk has been updated to reflect the Board's medium term financial plan and financial recovery plan for the period 2023/24 to 2025/26. A separate update on this risk will be presented to the committee at its November meeting.

7.2 As previously reported, there continues to be a delay to the processing of GP prescription payments arising from the transition to a new national payment system. The normal reporting 'lag' prior to changeover was 2 months (i.e. prescriber information provided to Health Boards is routinely 2 months in arrears of the actual period reported). At present this lag is 4 months. Actions in place to address this situation are expected to be fully implemented by end March 2024, which means that there will continue to be a higher level of 'accrued' (estimated) charges for the remainder of the current financial year. Given that the forecast for primary care prescribing is reflective of increased trends during the early part of 2023 there remains a significant risk to the forecast arising from the uncertainty relating to the actual position to date. This risk is being actively addressed and monitored via NHS Directors of Finance and Scottish Government.

Author(s)

Samantha Harkness
Senior Finance Manager
Sam.harkness@borders.scot.nhs.uk

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Clinical Governance Committee Minutes**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality & Improvement**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Clinical Governance Committee with the Board.

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Clinical Governance Committee 22 November 2023.

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Clinical Governance Committee minutes 13.09.23

Borders NHS Board
Clinical Governance Committee
Approved Minute

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 13 September** at 10am via Microsoft Teams

Present

Mrs F Sandford, Non-Executive Director (Chair)
Ms S Lam, Non-Executive Director (Chairing part of meeting)

In Attendance

Miss R Roberts, PA to Director of Quality & Improvement (Minute)
Mrs L Jones, Director of Quality & Improvement
Dr T Young, Associate Medical Director, Primary & Community Services
Mrs A Wilson, Director of Pharmacy
Dr C Cochrane, Director of Psychological Services
Mr P Grieve, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr S Whiting, Infection Control Manager
Mr P Williams, Associate Director of Nursing, Allied Health Professionals
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs E Dickson, Associate Director of Nursing/Head of Midwifery
Mrs S Horan, Director of Nursing Midwifery and Allied Health Professionals

1 Apologies and Announcements

Apologies were received from:
Mrs H Campbell, Non-Executive Director
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Mrs K Guthrie, Associate Director of Midwifery & GM for Women & Children's Services
Dr L McCallum, Medical Director
Mrs J Campbell, Lead Nurse for Patient Safety and Care Assurance
Mr G Clinkscale, Director of Acute Services
Dr S Bhatti, Director of Public Health
Mr R Roberts, Chief Executive
Dr A Cotton, Associate Medical Director, Mental Health Services
Dr J Bennison, Associate Medical Director, Acute Services

The Chair welcomed:
Mrs R Pulman, Nurse Consultant Public Protection (item 6.2)
Dr K Kiln, Deputising for Director of Public Health
Mr I Ritchie, Vice Chair Greater Glasgow & Clyde (observing)
Mrs L Milven, Infection Control Development Facilitator (observing)
Ms T Luke, Infection Control Nurse (observing)

The Chair confirmed the meeting was quorate.

2 Declarations of Interest

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

The **CLINICAL GOVERNANCE COMMITTEE** noted there were no new declarations made and previous declarations stood.

3 Minute of Previous Meeting

The minute of the previous meeting of the Clinical Governance Committee held on Tuesday 15 August 2023 were approved.

4 Matters Arising/Action Tracker

There were no Matters Arising from the previous meeting. The action tracker was discussed and updated accordingly.

5 Patient Safety

5.1 Infection Control Report

Mr Whiting attended to talk to the infection control report and provided an update on surgical site infection figures. Mr Whiting commented that theatre ventilation issues were highlighted during surveillance period of January to July and decision was made to cease activities which were deemed higher risk in terms of infection control. This allowed time for estates to look at ventilation systems, check differential air pressure and allow for extensive cleaning of duct work. The systems have been revalidated and are now within the acceptable range, surgery will now resume, and surveillance will continue. Mr Whiting reported that there is currently a task and finish group addressing surgical site infection issues, there are also other aspects of maintenance which are being picked up as a matter of urgency.

Mr Whiting commented that COVID outbreaks are being experienced and he will keep the Committee informed. Finally, hand hygiene audits continue with work ongoing to understand barriers to compliance. Education continues and supplier of hand gel had recently delivered ongoing education in some areas and will continue with that until end of December.

The Chair raised her concerns regarding attendance at the CAUTI group, Mr Whiting commented that Mr Grieve had recently taken over as chair and along with Mrs Horan they were looking at ways to improve attendance and focus on a clearer workplan and membership of the group.

Mrs Jones shared some comments on behalf of Mrs H Campbell around the good progress highlighted in the report. She enquired if it would be helpful from an assurance point of view to share actions and outcomes of spot checks in future reporting. It was also noted that there appeared to still be issue with E-Coli Bacteraemia, Mr Whiting commented that this will be a key focus of the CAUTI Group.

Following a question from Ms Lam discussion took place regarding comparisons with other boards relating to Hand Hygiene and if ideas are shared with Mr Whiting's counterparts.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured that systems are in place to address issues despite the frustration regarding results.

5.2 Hospital Standardised Mortality Report (HSMR)

Mrs Jones provided a brief overview of the content of the report. She commented that NHS Borders remain in normal limits in relation to the NHS Scotland funnel plot. Trends and comparisons are difficult due to how the data is collected externally. NHS Borders crude mortality sits slightly higher due to our palliative care unit, however Mrs Jones commented that due to increase in delayed discharge profile we are seeing more deaths in the hospital setting. Covid deaths remain at a constant level so less spikes being noted. The National definition has changed which will be reflected in future reporting.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the content.

5.3 Cabinet Secretary's Letter regarding Lucy Letby – additional item to original agenda

Mrs Jones brought letter to Committee for awareness. Mr Roberts and Mrs Jones have commenced a draught response setting out systems and processes in the organisation to provide assurance. The response will include areas we feel we have poorer quality data, Mrs Jones will provide this information to the Committee in the hope that they can find time to contribute to the response. She commented that the commonality across the country is that primary care data is not as developed as secondary care data which is something the organisation are keen to address.

Dr Young agreed that we have an opportunity to develop and share data and assurances across the services. The Chair commented that the Committee are happy to support colleagues in any improvement initiatives.

Ms Lam felt that this letter should go to the Staff governance Committee also.

The **CLINICAL GOVERNANCE COMMITTEE** noted the letter and welcomed the discussion.

6 Assurance

6.1 Medical Appraisal

In the absence of Dr Richmond and Dr Herlihy, Mrs Jones gave an updated on the report. The report provides assurance that the organisation is where it should be around appraisals and revalidation is met on all medical staff and consultants supported by the patient experience team who are external to the medical cohort. The Chair commented that it would be beneficial to the appraisee to have their appraiser work with them, she recognised that this is not always possible but would be keen for this to be developed going forward.

Dr Young commented that it would be useful to see the GP appraisal data come to the Committee for assurance. The committee agreed that this would be something that could be worked on and would be happy to see this information in line with the general move for the committee to have oversight of the whole organisation and not just acute services. Conversation followed regarding funding for Doctors to appraise others and how this fits in to SPA time which is allocated in Consultant job plans.

ACTION: Mrs Jones will discuss GP appraisal reporting with Dr Young.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the report.

6.2 Public Protection Annual Report

Mrs Pullman gave an update on the report, she commented on the Partnership inspection for adult support citing a very positive inspection and important strengths were identified in the children at risk of harm inspection which had previously been brought to the Committee. Improvement is planned following both inspections for the coming year focusing on actions within these plans.

Mrs H Campbell raised a point via Mrs Jones regarding challenge around sharing proportionate, appropriate information to which Mrs Pulman responded that as there are so many different systems in place this is a challenge, but they are mindful that the need to ensure information is available for all agencies across child and adult protection. This is working at present, the team are aware that information sharing is important and how this is done can be improved.

Ms Lam enquired about PREVENT agenda learning modules and if the difficulty in access is being seen across all boards, if this is the case could this be something NES could support with since they were involved in the PREVENT training initially. Mrs Pulman commented that there are conversations going on Nationally to address access to data.

Ms Lam also enquired about supervisor training and if the numbers of people trained were good, Mrs Pulman confirmed the figures were good.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the report.

6.3 Psychological Services Annual Report

Dr Cochrane talked to the report, she highlighted that a full-service review is planned for the first half of next year. They are also awaiting the National Psychological Therapy Specification publication following some delays along with updated waiting times guidance and matrix. All Psychologists have completed their HCPC renewal and signed up to Standards of Proficiency which commenced in September. Work following SAERs is ongoing and an increase in consultation is available to those in in-patient wards should that be required. Dr Cochrane gave an overview of the work of the Integrated Psychological Trauma Steering Group and training required to destigmatize trauma. Work is also ongoing with Occupational Health to develop support pathway for those who have experienced traumatic events at work.

Discussion took place around recruitment and workforce data and if there was anything to be learned from Dumfries and Galloway

Development of the support pathway for staff experiencing traumatic events at work was also discussed, the Committee asked if access to support would be available for other staff groups. Dr Cochrane confirmed that there is work being done around staff wellbeing and resilience and it is intended that anybody could self refer.

Dr Cochrane reported that there had been staff recruited on a fixed term basis which will help with resilience along with support from Dumfries and Galloway colleagues, but work continues for a more permanent solution, it is expected that the service review will highlight these areas and provide solutions.

Ms Lam asked about prevention and early intervention and a discussion followed about the intricacies of Psychology and Mental Health. There is work ongoing with GPs around early

intervention and how we encourage lifestyle changes. The Renew Service for example is one route where they have a range of options to offer working alongside wellbeing services to promote good psychological health. Mr Lerpiniere highlighted an issue around remote working and not having face to face therapy sessions having a negative impact on therapy. Further conversation took place on how psychological support should be adapted to fit what the patient requires in the most appropriate environment.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the report.

7 Effectiveness

7.1 Clinical Board update – Mental Health Services

Mr Lerpiniere attended to update the Committee on his report. Due to difficulties highlighted the Mental Health for Adults Team will be pausing new assessments of routine referrals for a period of time, it is foreseen that this will not impact on existing casework, urgent referrals or hospital discharge follow up. The impact will be on those being referred into the service and although waiting list is not long it is an impact that they would prefer to avoid, the assurance for the Committee is that referrals will be seen.

Mr Lerpiniere informed the Committee that a member of the Mental Health Team has been shortlisted for a National Award.

He commented that the falls and tissue viability reporting will be slightly different going forward to give the Committee a clearer picture of what is happening. He reported a decrease in Adverse events in Huntlyburn since change in shifts and that has been sustained.

Discussion took place regarding Junior Dr changeover and delays, this had been a specific issue in Mental Health which is largely out with the service's control.

Mrs Jones commented that these pressures are noted and will be raised at the Public Board, the executive team have reviewed these pressures in a lot of detail and controls are being put in place to ensure all referrals are vetted and prioritised appropriately.

On behalf of the Committee the Chair congratulated the Team on the National Award nomination and look forward to hearing the outcome.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured recognising the systems and process are in place but there will be difficult times ahead.

7.2 Clinical Board Update – Learning Disabilities Services

Mr Lerpiniere gave the Committee an update on the paper. He wanted to acknowledge the work that Mrs Tannahill had put into the service in her time with them, but she was sadly moving on to pastures new. The annual health check model is in development, the team are working closely with Public Health and progress is being made. Suitable accommodation remains an issue. Mr Lerpiniere reports that the patient previously discussed is now in a more positive placement, the intention is still to develop a resource that will enable them to be supported in the Borders.

Discussion took place in relation to autism assessments and the work required to provide these in particular for the adult population. He reported that there had been an autism study day involving service users which had been very informative for the service.

Mrs Horan raised the issue of relying on agency staff for LD services and Dr Cochrane commented that it is important to build resilience within the service especially around psychology input.

Mr Lerpiniere commented that the input from a psychology perspective had improved and applying some of the National strategies within the service is hoped to have an impact on resources required.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the report, recognising the difficulties but happy things are moving in the right direction.

7.3 Clinical Board update – P&CS Services

Mr Grieve was in attendance to expand on the P&CS report. He commented that data from delayed discharge work will be collated and shared with the organisation once they have looked more closely at the causes for delay. There is ongoing work on an integrated discharge implementation group which will feed into the urgent and unscheduled care programme board. These will be the key governance structures to oversee and implement the principles of discharge without delay. He noted that this approach has been agreed and the current discharge team and social work team have integrated but Mr Greive recognises that it will take time to fully integrate.

Work continues in Community Hospitals, in particular around rotas and staff management. AHP services workforce challenges continue coupled with a significant demand for services with a knock-on effect on waiting time.

Primary and Community Services who continue to support care homes across the borders, are embarking on a review of the support team which will be fed back to the Committee in future reporting once complete.

Mrs H Campbell enquired (via Mrs Jones) as to recruitment and discussion followed regarding the difficulties and financial restraints being felt. Mr Grieve will give more detail on this in future reporting, Mr Williams suggested he would liaise with Mr Grieve on how this is reported.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the report, understanding that there are still several difficulties in the system but assured that there is work underway to address these.

7.3 Clinical Board update – Acute Services

Mrs Dickson attended to give an update on the report. Acute services continue to see significant pressures throughout, compacted by delayed discharge and pressures being seen by social work and community hospitals. Delays continue to impact elective activity. Rise in incidence of Covid has affected both patients and staff and the ability to accommodate patients with beds and bays being closed due to infection control measures and staff absence.

Mrs Dickson informed the Committee that they had recruited to the Nurse Champion post for values-based medicine so was happy to bring some good news to the Committee.

Mrs Jones commented that stroke performance remains a concern, but work is ongoing to address this issue.

Elective footprint had been improving however there had been a recent spike in unscheduled surgical activity which has had an effect on surgical demands.

The Chair asked if there could be some data regarding the types of patients presenting at ED as the numbers from May to July don't seem significantly different but pressures in ED and downstream wards appear worse.

Discussion followed regarding the delays in the system and the impact these have on all services, in particular on smaller services within the Board. Mrs Jones commented that it would be possible to bring back more information on admissions and attendances within the acute services to get a better overview of where the biggest issues lie. Concerns regarding Dermatology and Haematology have been formally escalated to the Scottish Government in a hope that this will be considered in regional planning as we are in an untenable position.

Mrs Sandford handed Chair responsibilities to Ms S Lam – Non-Executive Director. From this point the meeting was not Quorate

Mrs Jones commented she would like to see some updated information on audiology position in future reporting.

ACTION: Audiology position to be included in Acute report

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the report.

8 Items for noting

The were no items presented for noting.

10 Any other business

Cabinet Secretary's letter – noted in patient safety section of agenda. (item 5.3)
There were no further items of competent business to record.

11 Date and time of next meeting

The chair confirmed that the next meeting of the Borders NHS Board's Clinical Governance Committee is on **Wednesday 22 November 2023** at **10am** via Teams Call.

The meeting concluded at 11:56am

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Quality and Clinical Governance Report – November 2023**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality and Improvement**
Report Authors:	**Julie Campbell - Lead Nurse for Patient Safety and Care Assurance, Joy Dawson – Research Governance Manager, Justin Wilson, Quality Improvement Facilitator - Clinical Effectiveness, Susan Cowe, Quality Improvement Facilitator - Person Centred Care**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to:

- Clinical governance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Safe
- Effective
- Person centred

2 Report summary

2.1 Situation

2.1.1 This exception report covers key aspects of clinical effectiveness, patient safety and person centred care within NHS Borders.

2.1.2 The Board is asked to:

- note the report and detailed oversight on each area delivered through the Board Clinical Governance Committee (CGC).

2.2 Background

2.2.1 NHS Borders, along with other Boards in Scotland, continue to face extreme pressures on services. Demand for services, although improving remains intense and is exacerbated by significant staffing challenges, across the health and social care system.

2.3 Assessment

2.3.1 Clinical Effectiveness

The Board CGC met on the 22 November 2023 and discussed papers from all four clinical boards.

2.3.2 The annual paper on Duty of Candour was considered by the CGC. During the reporting period of 1 April 2022 to 31 March 2023 there were 5,073 adverse events or near miss records reported on the NHS Borders Adverse Event Reporting System. On final evaluation there were 39 adverse events which activated the organisational Duty of Candour (DoC). These were unintended or unexpected events that resulted in death or one of the harms as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition. The correct procedure for Duty of Candour was carried out for all events investigated under a management review of significant adverse event review. NHS borders has also included pressure damage cases in its Duty of Candour reporting although this is variation to this across NHS Scotland. For some pressure damage cases it was identified that there was some room for improvement relating to documentation of steps taken to enact the duty of candour and this is an area the patient safety team are focusing on with nursing leadership teams. The Committee were assured by the contents of report.

2.3.3 The annual report on blood transfusion was presented to the CGC. There has been significant progress in this area resulting from the effort being made by transfusion committee members and the clinical lead. There are some areas where improvement is required in relation to training and follow up of adverse events and the committee asked for additional work in this area to be supported by the acute clinical board. The committee were partially assured.

2.3.4 The CGC received the annual report for research governance and were assured by the report. There has been a reduction in the number of open studies in NHS Borders in 2022/23 reflecting some of the capacity constraints in front line clinical teams to open new studies. Oncology and Haematology have been some of the areas that normally have the highest research activity. Pressures in Haematology previously reported to the Board haver contributed to the reduction in new studies opening in this area as one example. The team are hopeful of rebuilding the number of new studies opened each year and are working on growth in some new service areas where there are clinical staff with a keen research interest.

2.3.5 The CGC received a report on Primary and Community Services. There was a discussion on the risk around staffing the current community hospital model and the piece of work which has been launched to review the role and purpose of community

hospitals in the future. The Committee were keen to understand how this is progressing and recognised that for some time the community hospitals have been highlighted significant pressures around patients delayed to their next stage of care. There as discussion around workforce pressures in some Allied Health Professional roles and reference to a detailed piece of workforce analysis in this area to look at innovation opportunities akin to that undertaken in nursing. The CGC was keen to consider this at the Board in due course. The committee was partially assured by the Primary and Community Services report.

2.3.6 The CGC received a report on acute services. The service remains under pressure with a high level of delays effecting unscheduled and elective flow but noted some early progress in reducing delay which had resulting in a positive impact on patients waiting for admission within the emergency department. The committee remained concerned about the impact the delays across the system were having on patients and staff and the ability to shut surge beds and also fully deliver an elective programme but were partially assured by the work underway through the surge plan to try and address this. In particular, the impact on access to the stroke unit and also inpatient elective beds for Orthopaedics, General Surgery and Gynaecology were areas the committee remain concerned about. Positive work underway planned care was discussed including work to improve access in Ophthalmology for cataract surgery, the movement of the planned surgical assessment unit to a larger area to provide greater protection of elective workload and the 'Making Theatres Great' project to improve pathways for inpatient/day case treatment. Diagnostic and Cancer waits remain an area of priority for the acute service and performance in these areas has been good but levels of demand for diagnostic service remains a key area of risk for NHS Borders long term planning. Womens and Childrens services have been experiencing a period of significant workforce strain. The team are working to provide stability during this period and a more detailed overview of the work underway will be considered at the next CGC meeting. Good progress continues to be made of registered nursing posts although the risk around recruiting health care support workers into the acute services was flagged acknowledging the resulting impact this can have on workforce within the social care system. Critical workforce pressures remain in dermatology and haematology. The Committee were partially assured given the level of risk acute services continue to carry due to increased demand for beds, additional workforce requirements resulting from this and also the specific capacity problems in dermatology and haematology and were keen to ensure the Board continue to be sighted on these challenges and the need for a whole system and regional response.

2.3.7 The CGC considered a paper from Mental Health Services. Pressures within the Psychiatry workforce highlighted at previous Board meetings remain. Several actions have been agreed to mitigate risk and prioritise areas of greatest clinical need. Progress in Child and Adolescent Mental Health waits remains an area of focus on the service but is not yet meeting the waiting times standard required. There was an unannounced inspection carried out by Healthcare Improvement Scotland in September 2023 to all four Mental Health inpatient wards. The formal report has been received which was predominantly positive but had a number of areas for improvement, identifying a lack of storage space and the maintenance of the environment. This is being addressed in collaboration with the estates team. The CGC recognised the steps being taken within mental health to balance clinical risk but due to this significant pressure were only able to confirm partial assurance in this area.

2.3.8 The CGC received a report from the Learning Disability (LD) Service. The Mental Welfare Commission for Scotland (MWC) have visited the LD service on 2 November. This was a pilot inspection, of 2 Community LD teams and 4 community MH teams across Scotland. A report will be provided by the MWC from these visits and detail will provided to the CGC in due course. Updates were given on the LD annual health checks project which is making good progress and on the Coming Home Programme. Whilst progress is being made to bring patients who are placed out of area home there are still some significant challenges in developing appropriate provision locally. The team are actively working on this to come up with specific plans for any clients placed out of area. The Committee were assured in the processes recognising there are still areas of concern but work is underway to address these.

2.3.9 Patient Safety

2.3.10 Maternity

A clinic to support birth choices for women in the Scottish Borders has been developed. The Thistle Clinic is a specialist midwifery led clinic within the Borders General Hospital. The clinic provides an opportunity to discuss mode of birth, location of birth and aid the development of a personalised birth preference plan. The clinic is aimed at women, birthing people and their birth partners, who wish to have an elective caesarean section, have a history of complex birth, require additional support due to adverse life events or require additional birth planning. Those attending can discuss their birth choice, including reviewing previous notes, and will be provided with evidence based information and guidelines to facilitate fully informed decisions.

2.3.11 Women and birthing people including birth partners can also attend to reflect on their birth experience. This should ideally be a minimum of 6 weeks after birth. We recognise some birth experiences can leave some with unanswered questions, feelings of disappointment if the birth was not what they hoped for. The process of birth reflections can support women and birthing people and their birthing partners to:

- Reflect on their birth experience, feel listened to and validated in their feelings
- Provide feedback on the care they received
- Resolve unanswered questions about their birth

2.3.12 Leadership Walk rounds

Leadership walk rounds have extended to Outpatients, Intensive Therapy Unit (ITU) and Dialysis and although the areas vary to that of acute inpatient areas in regards to patient group they have shown to be beneficial. The Clinical Nurse Manager (CNM) and Quality Improvement Facilitator for Maternity Services in collaboration with the Lead Nurse for Patient Safety and Care Assurance are now working to design an approach suitable for maternity services which has been used in other health boards. This approach will then extend into Mental Health and Community Teams to enhance the existing approach.

2.3.13 The current Leadership Walk round proforma used during each walk round aims to help the leadership team understand the quality of care, celebrate excellence and acknowledge challenges each area is experiencing. Following each walk round The Lead Nurse for Patient Safety and Care Assurance and the CNM aim to build a consistent approach and rebuild momentum with teams to offer support for them to initiate improvement actions for their individual areas. From the themes identified

within the walk round, teams are expected to choose any topic that makes a difference to one or more of the following:

- Patient safety
- Patient experience
- Staff experience
- The environment

2.3.14 The Associate Director of Nursing (ADoN) and Lead Nurse for Patient Safety and Care Assurance are in discussion to ensure that continual improvement is made to our governance structures to bring the outputs from walk rounds into Clinical Management Team (CMT) and Clinical Governance Groups. The Patient Safety Team have developed a flash report which is completed by the facilitator following each walk round and shared with the Senior Charge Nurse (SCN) and CNM. The flash report can be used to present to the CMT to give assurance of the quality of care, provide examples of improvement and includes staff / patient feedback. Figure below is an example of the Leadership Walk round flash report:

Leadership Walk round

NHS Borders

Area:	Date:	CNM: SCN: Facilitator:
Objectives:		Patient Feedback:
Priorities:		Staff Feedback:

2.3.15 Tissue Viability

As a recommendation to a recent Significant Adverse Event Report (SAER) the Patient Safety Quality Improvement Facilitator for the pressure damage work stream has been asked to review the current escalation plan to support NHS Borders nursing staff when they have a request for topic specialist advice regarding complex wound management. This is to give Senior Management / CNM's a clear pathway of escalation. The escalation pathway must include clear instructions both in and out with normal working hours. The Tissue Viability Nursing hours have been extended to full time on a temporary basis to support the current workload pressures.

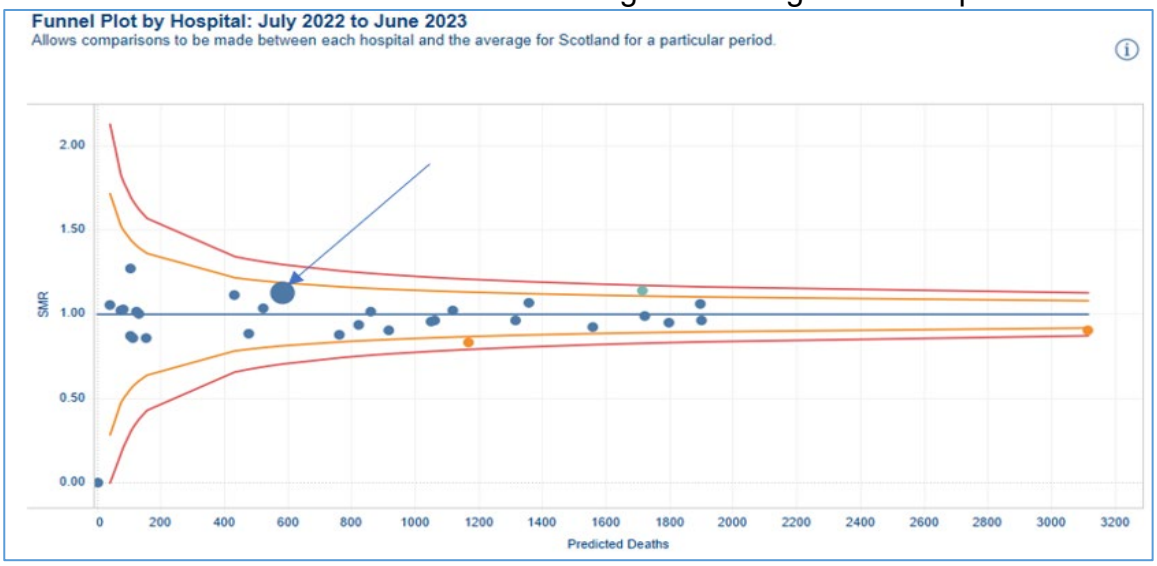
2.3.16 Deteriorating Patient

The Patient Safety Quality Improvement Facilitator for the deteriorating patient work stream in collaboration with expert clinicians is supporting in the education of staff relating to discussions to maintain a medical focus on realistic expectations to

outcomes and provisions of care by introducing Treatment Escalation Plans (TEP) within all adult in patient areas, including community hospitals and mental health. To support this initiative a clinician has been employed on a temporary basis to help facilitate the role out.

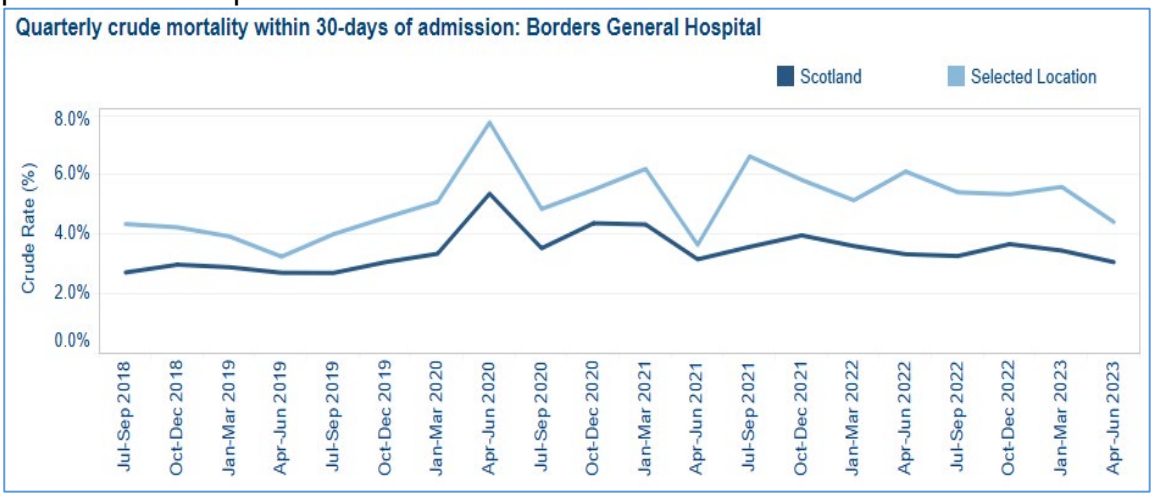
2.3.17 Hospital Standardised Mortality Rates and Crude Mortality

NHS Borders Hospital Standardised Mortality Rate (HSMR) for the period July 2022 to June 2023 is 1.12. This figure is based on 655 observed deaths divided by 584 predicted deaths. The NHS Scotland funnel plot below shows NHS Borders HSMR remains within normal limits based on the single HSMR figure for this period:



*Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.18 NHS Borders crude mortality rate for quarter April 2023 to June 2023 was 4.4% and is presented in Graph 1 below:



*Contains deaths in the Margaret Kerr Palliative Care Unit

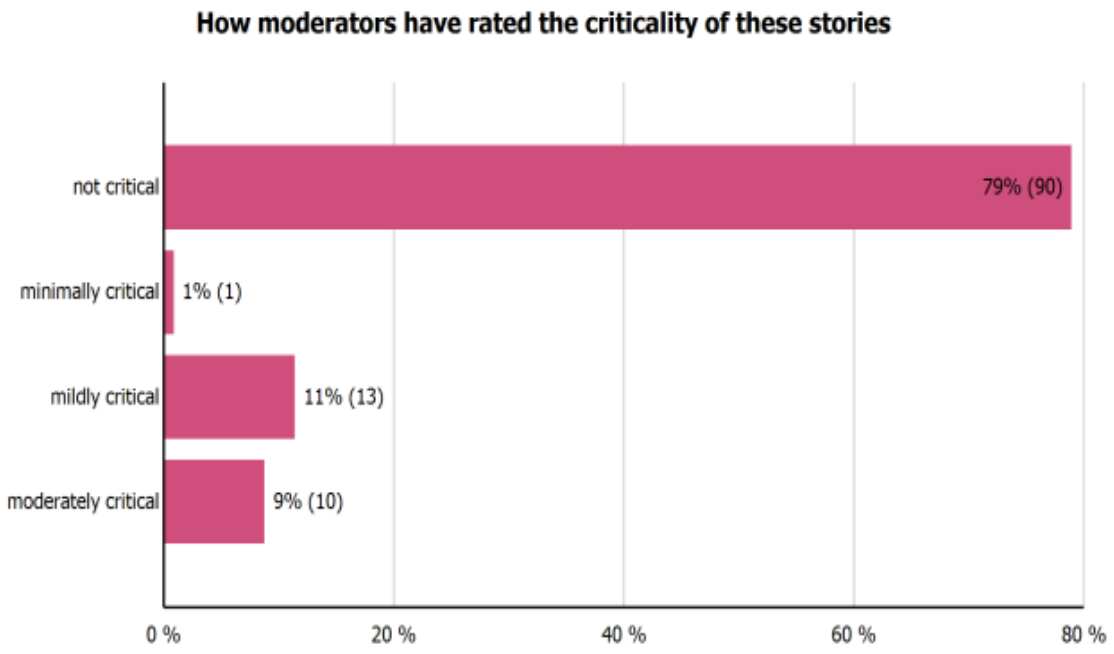
2.3.19 A sample of deaths are reviewed through the NHS Borders mortality review system each month to identify learning, and themes from this work are reported annually to the Board Clinical Governance Committee.

2.3.20 Patient Experience

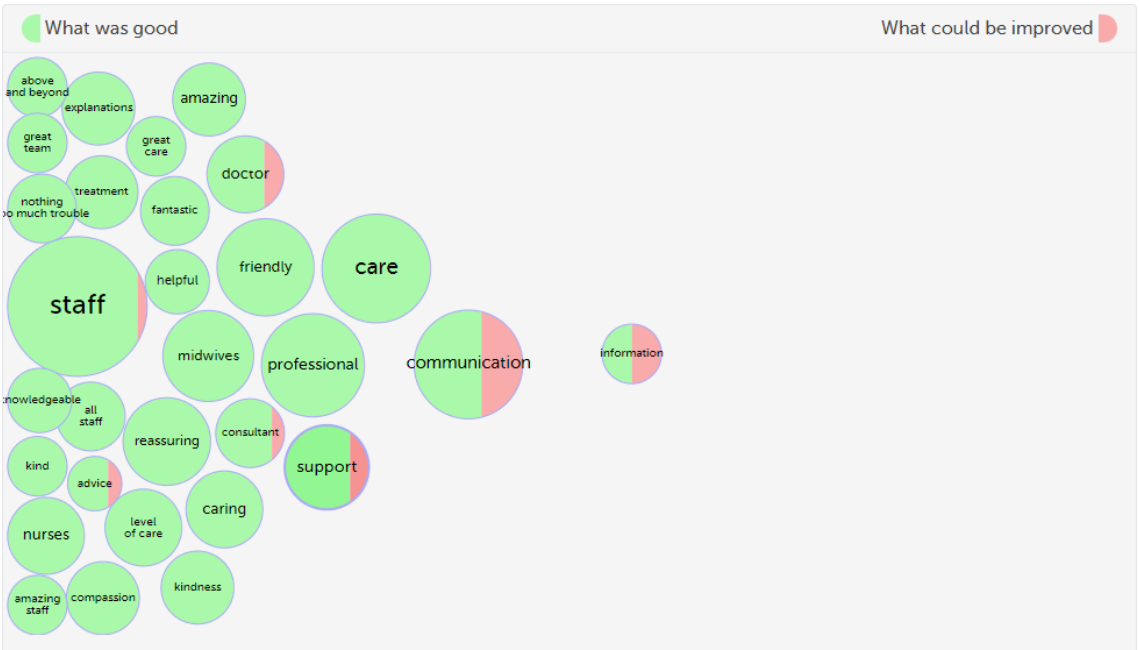
2.3.21 Care Opinion

For the period 1 April 2023 to 30 September 2023, 114 new stories were posted about NHS Borders on Care Opinion. The graph below shows the number of stories told in that period. As at 19 October 2023 these 114 stories had been viewed 9,900 times:

2.3.22 Graph 2 provides a description of the criticality of the 114 stories:



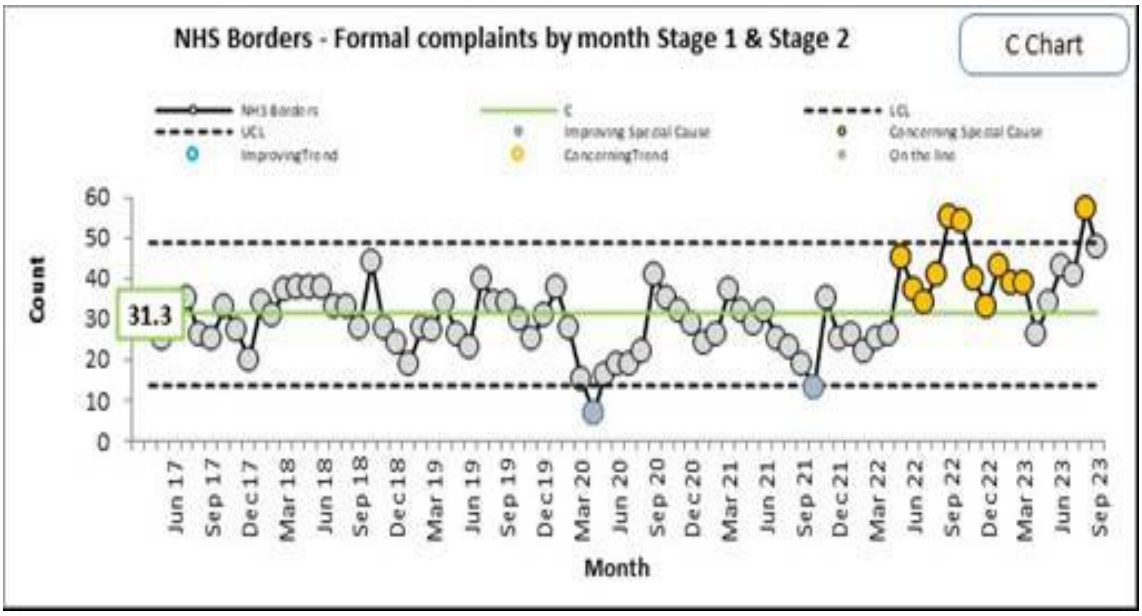
2.3.23 The word clouds below summarise 'what was good' and 'what could be improved' in Care Opinion posts for this period:



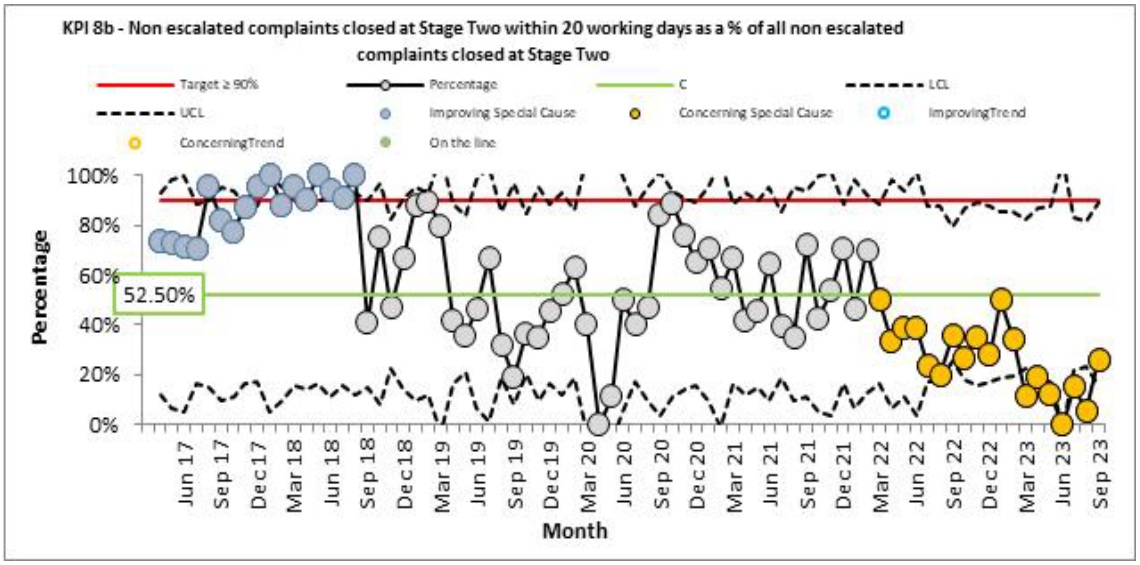
What was good?

What could be improved?

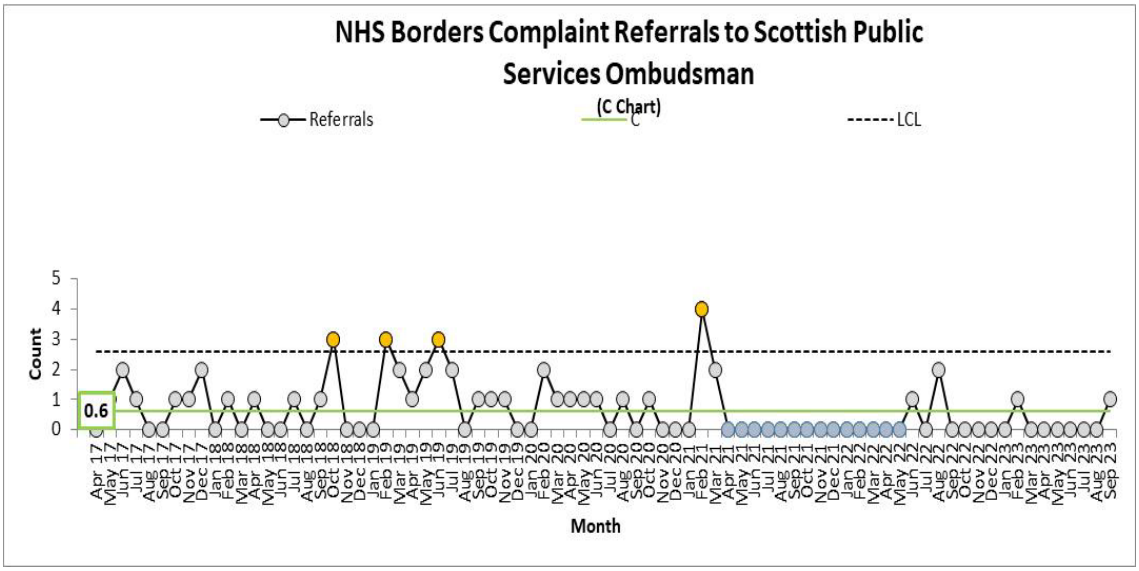
2.3.24 Graph 3 below gives the number of Stage 1 and Stage 2 complaints received by month. Since May 2022, with the exception of April 2023, the number of complaints being received has been above average. The ongoing increase in the number of complaints, resulting from the continued pressure within clinical services, is placing a significant workload strain on both the Patient Experience Team (PET) and frontline staff involved in the review of individual complaints. Additional capacity has been added to the PET team on a short term basis to support this increase in workload:



2.3.25 Graph 4 below shows the percentage of complaints responded to within 20 working days. Frontline services continue to experience clinical pressures which have impacted on the ability of frontline clinical staff to respond to complaint investigations within normal timescales. This together with the increase in the number of complaints has resulted in the Patient Experience Team being unable to sustainably deliver against the 20-working day target. Additional capacity has been out into the Patient Experience Team to address this but demand has continued to grow and there has not yet been a reduction in waits for response:



2.3.26 The Scottish Public Services Ombudsman (SPSO) are the final stage for complaints about most devolved public services in Scotland including the health service, councils, prisons, water and sewage providers, Scottish Government, universities and colleges. The additional scrutiny provided by the involvement of the SPSO is welcomed by NHS Borders as this gives a further opportunity to improve both patient care and our complaint handling. The SPSO are experiencing the same demand pressures at this time, resulting in extended periods for reviews by the SPSO. Graph 5 below shows complaint referrals to the SPSO up to 30 September 2023:



2.3.27 COVID Inquiries

The Scottish COVID-19 Inquiry's Health and Social Care Impact Hearings commenced on 24 October 2023. These hearings (live and recorded) are available through either the Inquiry's website: https://www.covid19inquiry.scot/ or YouTube channel.

2.3.28 Five Modules have already begun in the UK Covid Inquiry: Resilience and preparedness (Module 1), Core UK decision-making and political governance (Module 2), Impact of the Covid-19 pandemic on healthcare (Module 3), Vaccines and therapeutics (Module 4) and most recently Procurement (Module 5) which started on 24 October 2023. Current and previous hearings are available on https://www.youtube.com/@UKCovid-19Inquiry. Further information about the UK Inquiry, including future dates and times for hearings can be found on the UK Inquiry's website (https://covid19.public-inquiry.uk/).

2.3.29 Quality/ Patient Care

Following the impact of the COVID-19 pandemic services continue to recover and respond to significant demand with heightened workforce pressure across health and social care. This has required adjustment to core services and non-urgent and routine care. This prioritisation has necessitated the step down of services resulting in increased patient waits and a backlog of demand. The ongoing unscheduled demand and delays in flow across the system remain an area of concern with concerted efforts underway to reduce risk in this area.

2.3.30 Workforce

Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery from the pandemic response and resulting pressures across health and social care. Key workforce pressures have required the use of bank, agency and locum staff groups and further exploration of extended roles for the multi-disciplinary team. Mutual aid has also been explored for a few critical specialties where workforce constraints are beyond those manageable locally. There has been some progress locally in reducing gaps in the registered nursing workforce and positive levels of international recruitment. There continues to be an outstanding response from staff in their effort to sustain and rebuild local services, but many staff continue to feel the strain of workforce challenges and this needs to remain an area of constant focus for the Board.

2.3.31 Financial
Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery from the pandemic response and resulting pressures across health and social care. As outlined in the report the requirement to step down services to prioritise urgent and emergency care has introduced waiting times within a range of services which will require a prolonged recovery plan.

2.3.32 Risk Assessment/Management
Each clinical board is monitoring clinical risk associated with the need to adjust and remobilise services following the pandemic response.

2.3.33 Equality and Diversity, including Health Inequalities
An equality impact assessment has not been undertaken for the purposes of this awareness report.

2.3.34 Climate Change
No additional points to note.

2.3.35 Other Impacts
No additional points to note.

2.3.36 Communication, Involvement, Engagement and Consultation
This paper is for awareness and assurance purposes and has not followed any consultation or engagement process.

2.3.37 Route to the Meeting
The content of this paper is reported to Clinical Board Clinical Governance Groups and Board Clinical Governance Committee.

2.4 Recommendation

The Board is asked to:

- note the report.

Glossary:
Clinical Governance Committee (CGC)
Duty of Candour (DoC)
Learning Disabilities (LD)
Intensive Therapy Unit (ITU)
Clinical Nurse Manager (CNM)
Associate Director of Nursing (AdoN)
Clinical Management Team (CMT)
Senior Charge Nurse (SCN)
Significant Adverse Event Review (SAER)
Treatment Escalation Plan (TEP)
Hospital Standardised Mortality Rate (HSMR)
Patient Experience Team (PET)
Scottish Public Services Ombudsman (SPSO)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Infection Prevention and Control Report – November 2023**
Responsible Executive/Non-Executive:	**Sarah Horan, Executive Director of Nursing, Midwifery and Allied Health Professionals**
Report Author:	**Lynsey Milven, Quality Improvement Facilitator** **Sam Whiting, Infection Control Manager**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe

2 Report summary

2.1 Situation

This report provides an overview for Borders NHS Board of infection prevention and control with particular reference to the incidence of Healthcare Associated Infection (HAI) against Scottish Government targets.

2.2 Background

The format of this report is in accordance with Scottish Government requirements for reporting HAI to NHS Boards.

2.3 Assessment

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1– Board Wide Issues

1.0 Key Healthcare Associated Infection Headlines

1.1 NHS Borders had a total of 12 *Staphylococcus aureus* Bacteraemia (SAB) cases between April 2023 and August 2023, 6 of which were healthcare associated infections.

1.1a The Scottish Government has set a target for each Board to achieve a 10% reduction in the healthcare associated SAB rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline) which equates to no more than 20 cases. We are currently on target to achieve this.

1.2 NHS Borders had a total of 8 *C. difficile* Infection (CDI) cases between April 2023 and August 2023, 6 of which were healthcare associated infections.

1.2a The Scottish Government has set a target for each Board to achieve a 10% reduction in the healthcare associated CDI rate per 100,000 TOBDs by the end of 2023/24 (using 2018/19 as the baseline) which equates to no more than 12 cases. We are not currently on target to achieve this.

1.3 NHS Borders had a total of 53 *E. coli* Bacteraemia (ECB) cases between April 2023 and August 2023, 31 of which were healthcare associated.

1.3a The Scottish Government set a target for each Board to achieve a 25% reduction in the healthcare associated ECB rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline) which equates to no more than 32 cases. We are not currently on target to achieve this.

2.0 *Staphylococcus aureus* Bacteraemia (SAB)

See Appendix A for definition.

2.1 Between April and July 2023, there have been 12 cases of Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and no cases of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia.

2.2 Figure 1 shows a Statistical Process Control (SPC) chart showing the number of days between each SAB case. The reason for displaying the data in this type of chart is due to SAB cases being rare events with low numbers each month.

2.3 Traditional charts which show the number of cases per month can make it more difficult to spot either improvement or deterioration. These charts highlight any statistically significant events which are not part of the natural variation within our health system. The graph shows that there have been no statistically significant events since the last Board update.

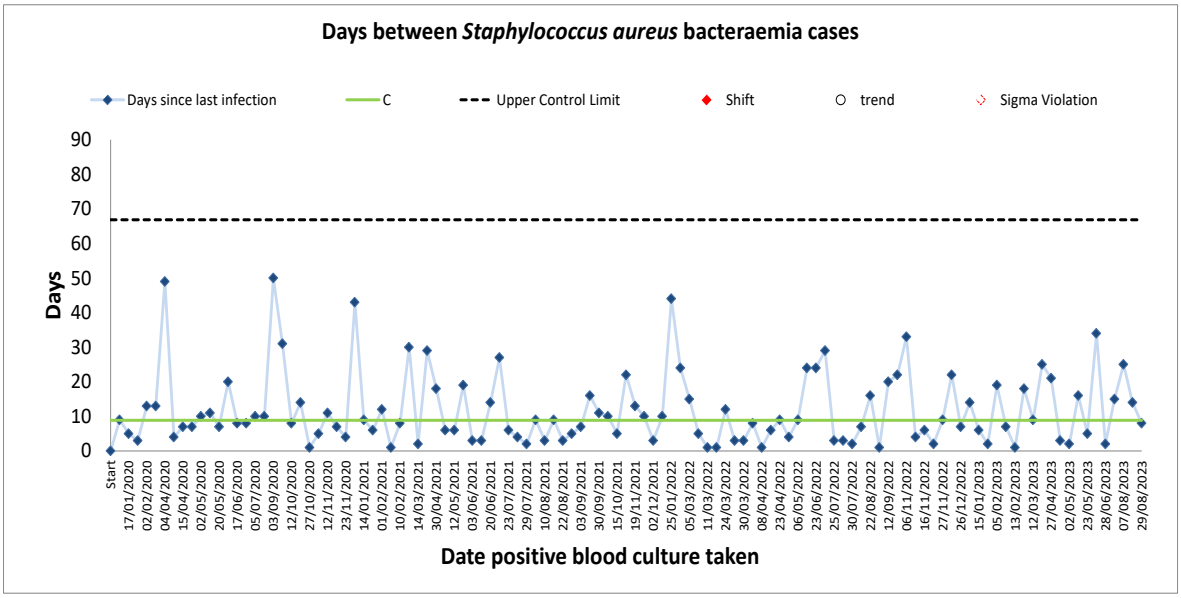
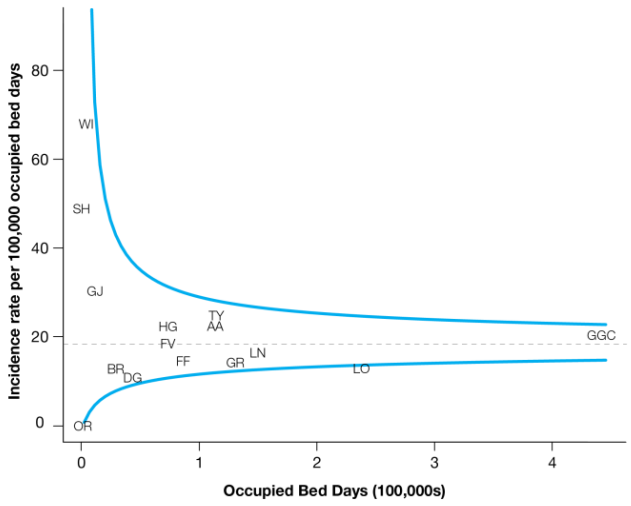


Figure 1: NHS Borders 'days between' SAB cases (January 2019– August 2023)

2.4 In interpreting Figure 1, it is important to remember that as this graph plots the number of days between infections, we are trying to achieve performance above the green average line.

2.5 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 2 below shows the most recently published data as a funnel plot of healthcare associated SAB cases as rates per 100,000 Total Occupied Bed Days (TOBDs) for all NHS boards in Scotland in Quarter 2 2023 (Apr 2023 – Jun 2023).

2.6 During this period, NHS Borders (BR) had a rate of 12.8 which was below the Scottish average rate of 18.3.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.

Key to NHS Boards

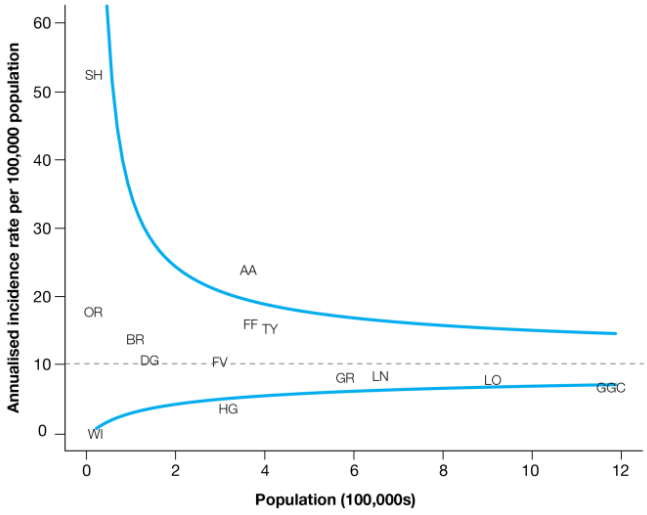
AA = Ayrshire & Arran
BR = Borders
DG = Dumfries & Galloway
FV = Forth Valley
FF = Fife
GR = Grampian
GGC = Greater Glasgow & Clyde
HG = Highland
LN = Lanarkshire
LO = Lothian
NWTC = National Waiting Times Centre
OR = Orkney
SH = Shetland
TY = Tayside
WI = Western Isles

Figure 2: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q2 2023

2.7 A funnel plot chart is designed to distinguish natural variation from statistically significant outliers. The funnel narrows on the right of the graph as the larger health Boards will have less fluctuation in their rates due to greater Total Occupied Bed

Days. Figure 2 shows that NHS Borders was within the blue funnel which means that we are not a statistical outlier.

2.8 Figure 3 below shows a funnel plot of community associated SAB cases as rates per 100,000 population for all NHS boards in Scotland in Q2 2023.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Figure 3: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q2 2023

2.9 During this period NHS Borders (BR) had 4 cases resulting in a rate of 13.8 per 100,000 population which was above the Scottish average rate of 9.6. It is worth noting that community acquired SAB cases had no healthcare intervention prior to the positive blood culture being taken. We are not a statistical outlier from the rest of Scotland.

3.0 *Clostridioides difficile* infections (CDI)

See Appendix A for definition.

3.1 Figure 4 below shows a Statistical Process Control (SPC) chart showing the number of days between each CDI case. As with SAB cases, the reason for displaying the data in this type of chart is due to CDI cases being rare events with low numbers each month. The graph shows that there have been no statistically significant events since the last Board update.

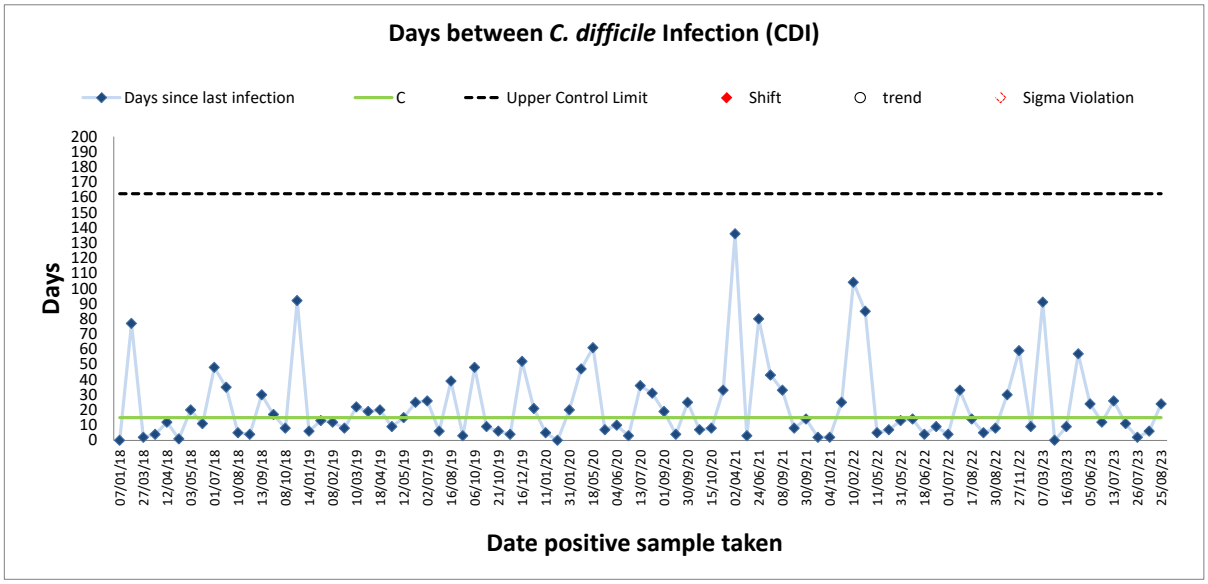
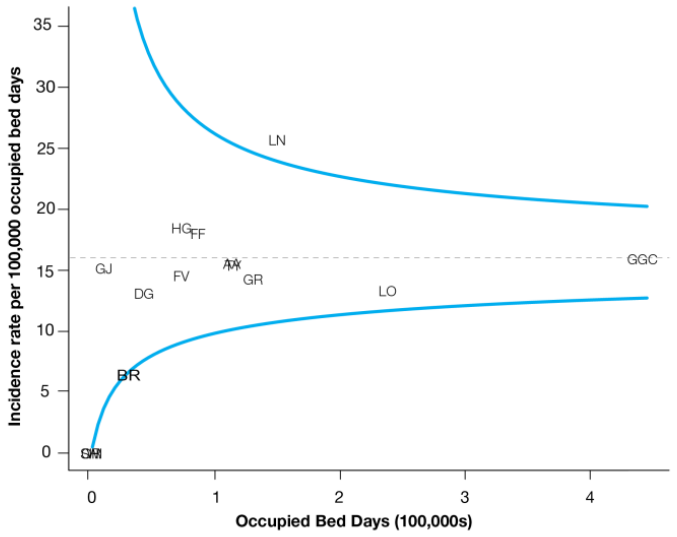


Figure 4: NHS Borders days between CDI cases (January 2018 – August 2023)

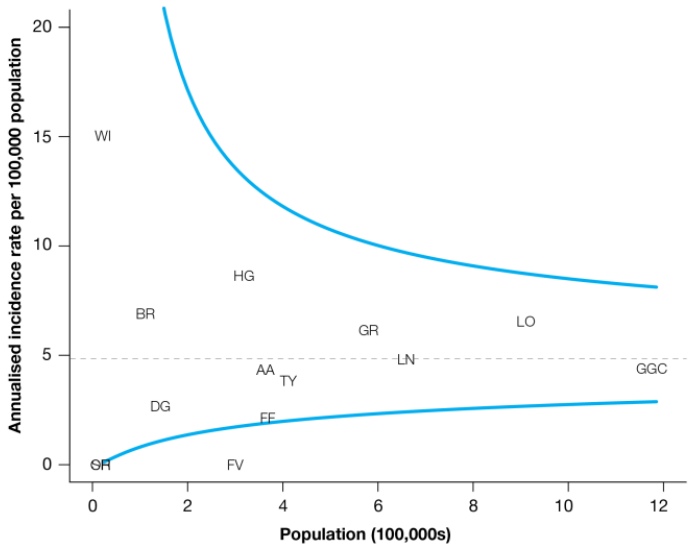
3.2 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 5 below shows a funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q2 2023. The graph shows that NHS Borders (BR) had a rate of 6.4 which was below the Scottish average rate of 16.1.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Orkney, NHS Shetland and NHS Western Isles overlap, as do NHS Ayrshire and Arran and NHS Tayside.

Figure 5: Funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q2 2023

3.3 Figure 6 below shows a funnel plot of CDI incidence rates (per 100,000 population) of community associated infection cases for all NHS Boards in Scotland in Q2 2023. The graph shows that NHS Borders (BR) had a rate of 6.9 which was above the Scottish average rate of 4.8.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS Orkney and NHS Shetland overlap.

Figure 6: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q2 2023

4.0 *Escherichia coli (E. coli)* Bacteraemia (ECB)

4.1 The primary cause of preventable healthcare associated ECB cases is Catheter Associated Urinary Tract Infection (CAUTI) as shown in Figure 7 below.

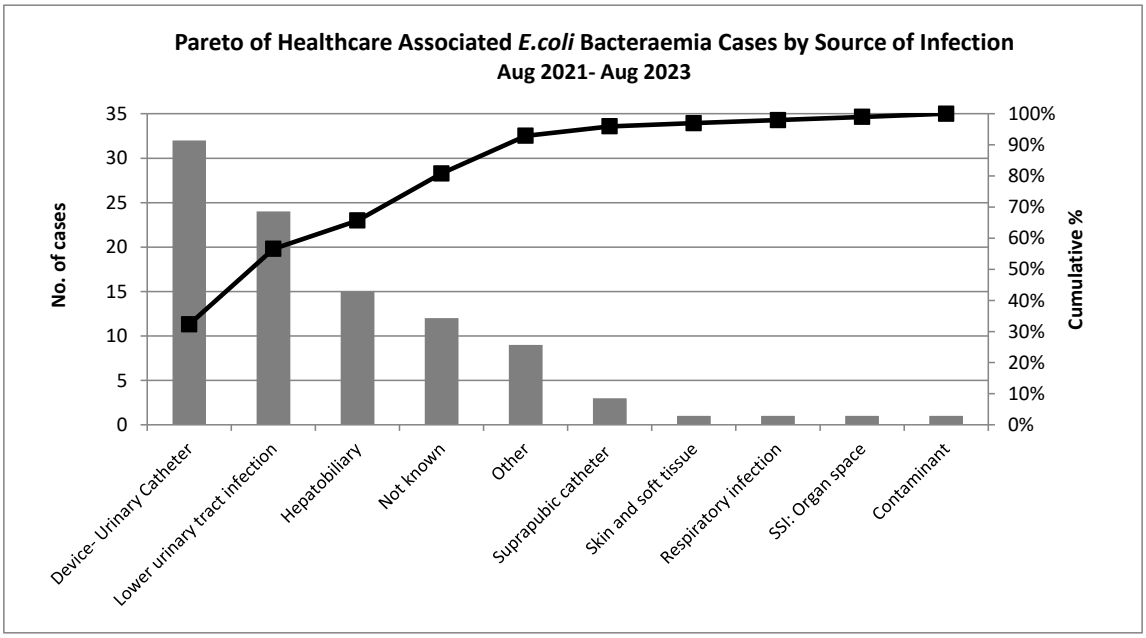


Figure 7: Pareto chart of healthcare associated ECB cases by source of infection

4.2 Figure 8 shows a statistical process control chart of the total number of healthcare associated and community acquired *E.coli* bacteraemia (ECB) cases per month. The chart shows that the total number of cases reported per month was within expected limits and there have been no statistically significant events. Please note that in

contrast to previous statistical process control graphs, Figure 8 is a count of cases per month rather than the number of days between cases.

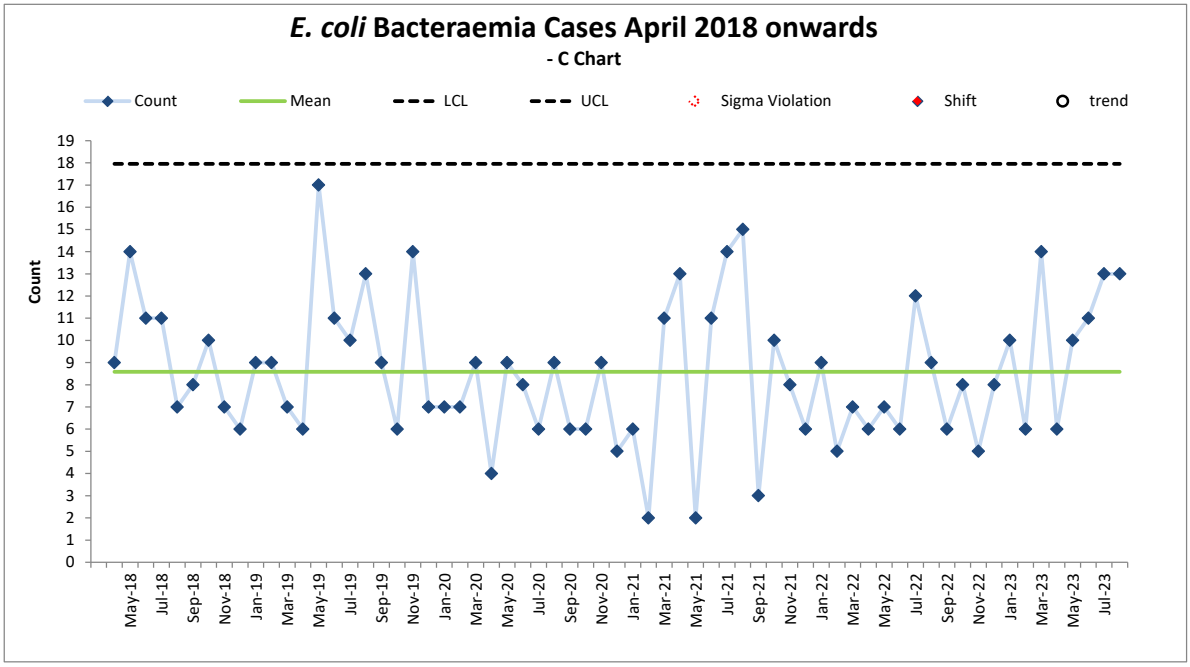
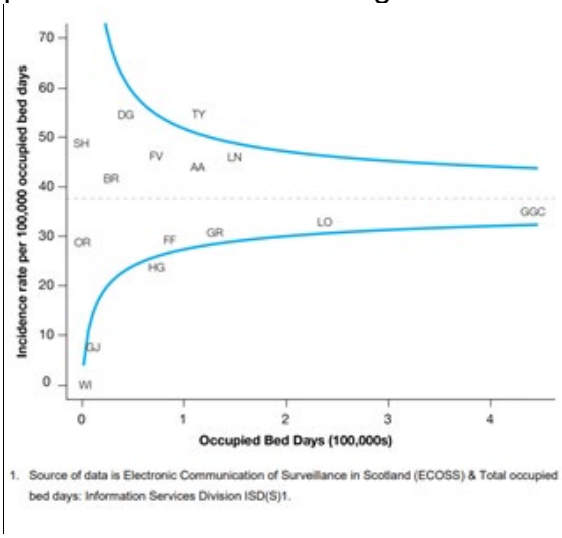


Figure 8: Statistical process chart (SPC) of all *E.coli* bacteraemia cases per month

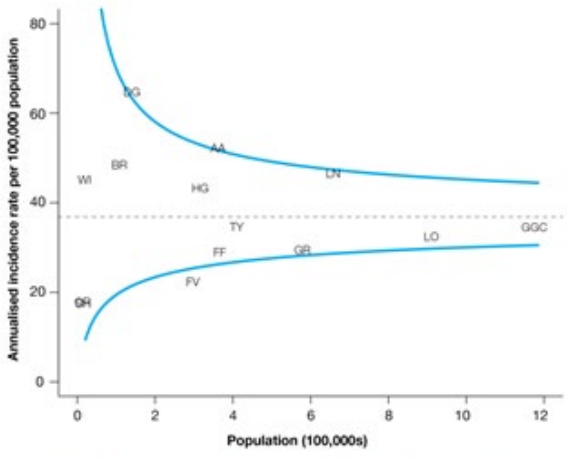
4.3 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 9 below shows a funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q2 2023. NHS Borders (BR) had a rate of 41.7 for healthcare associated infection cases which was above the Scottish average rate of 37.6 but we are not a statistical outlier.

4.4 Figure 10 below shows a funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q2 2023. NHS Borders (BR) had a rate of 48.4 for community associated infection cases which was above the Scottish average rate of 36.7 but we are not a statistical outlier. It is worth noting that community acquired ECB cases had no healthcare intervention prior to the positive blood culture being taken.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.

Figure 9: Funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q2 2023



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS Orkney, and NHS Shetland overlap.

Figure 10: Funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q2 2023

5.0 NHS Borders Surgical Site Infection (SSI) Surveillance

5.1 The Scottish Government paused the requirement for mandatory surgical site infection (SSI) surveillance on the 25th of March 2020. There has been no indication of a potential date for re-starting national SSI surveillance.

5.2 Due to sickness absence within IPCT it has not been possible to report on SSI surveillance for August and September 2023. It is anticipated that data for this period will be available for inclusion in the next monthly report.

6.0 Hand Hygiene

6.1 During August and September 2023, the Infection Prevention and Control Team conducted hand hygiene audits across 15 of areas across NHS Borders. The results are summarised in the table below by staff group.

Staff Group	Aug/Sep
Nurses	67%
Doctors	47%
Ancillary	66%

6.2 There has been steady improvement of glove use across all staff groups since the first audit in January 2023 (73%) to the most recent audit in August (88%).

6.3 A multi-modal action plan is progressing including a focus on leadership, behavioural change, access to hand gel and education.

6.4 IPCN are trialling a new educational method to engage staff in brief interactions within ward areas prior to further audits being completed at the end of November 2023.

7.0 Infection Prevention and Control Compliance Monitoring Programme

7.1 Between April and October 2023, spot checks were undertaken in a total of 49 clinical areas across NHS Borders with an average compliance of 91%.

7.2 Following a review of the audit process, full Infection Control audits recommenced in March 2023. There were 28 full audits undertaken between March and October 2023 with an average score of 89%.

8.0 Cleaning and the Healthcare Environment

For supplementary information see Appendix A.

8.1 Health Facilities Scotland (HFS) publishes quarterly reports on cleanliness standards and the estates fabric across NHS Scotland. The most recently published report covers the period July – September 2023. Figure 11 below shows NHS Borders cleaning compliance against the NHS Scotland average by quarter. In the period July – September 2023, the cleanliness score for NHS Borders was 95.6%. In the same period, the estates score was 97.5%.

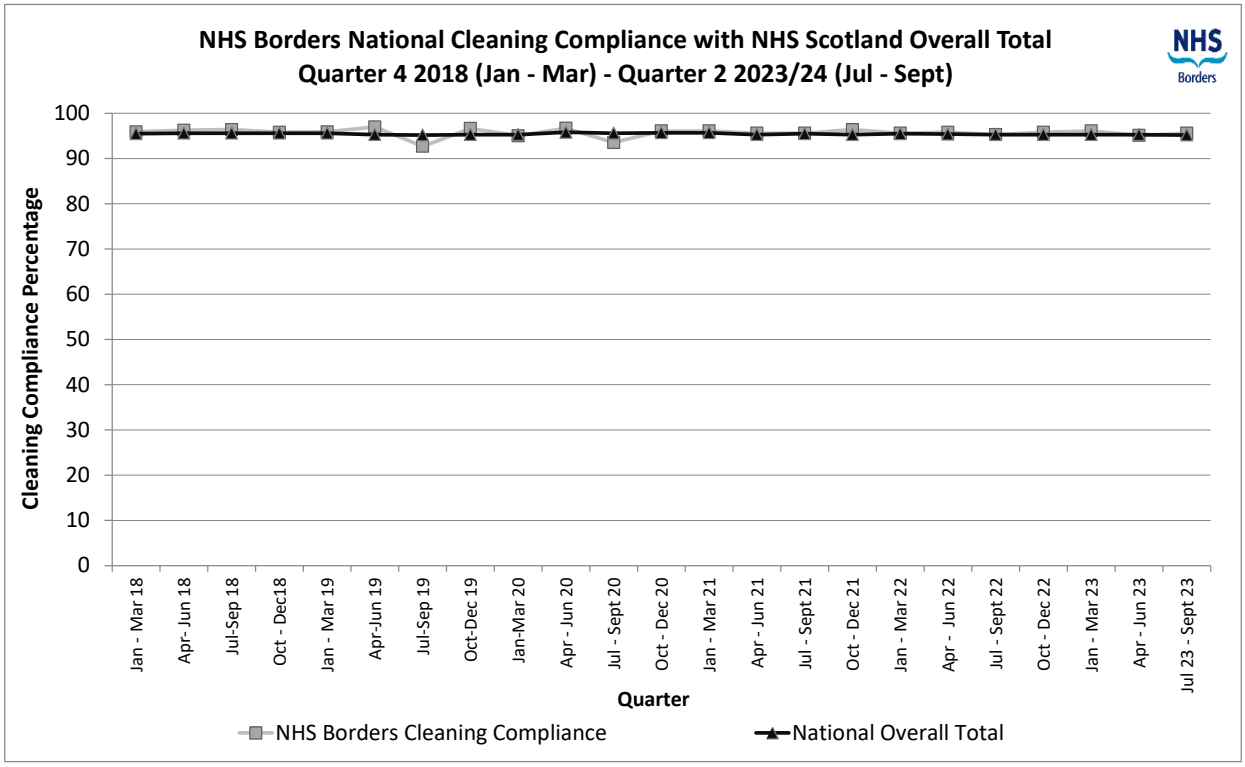


Figure 11: NHS Borders cleaning compliance against the NHS Scotland average by quarter

9.0 2023/24 Infection Control Work Plan

9.1 The Infection Prevention and Control Team provide both a reactive and proactive service. Responding to significant unexpected events or peaks of clinical activity such as outbreak management requires flexing resources away from proactive to reactive activities impacting on Work Plan progress.

9.2 There are currently seven overdue actions in the 2023/24 Infection Control Work Plan of which 2 were assessed as medium risk and the remainder low risk.

10.0 Outbreaks/ Incidents

- **COVID-19**

10.1 Since the last Board meeting, there have been 11 COVID-19 clusters for which a Problem Assessment Group (PAG) and/or Incident Management Team (IMT) has been held. A summary for each closed cluster as at 9th November 2023 is detailed in the table below.

10.2 Learning from each incident is captured and acted upon in real time where appropriate.

Area affected	Total positive patients	Total positive staff	Total deaths
Ward 4 & MAU	21	0	0
Ward 7	10	REDACTED	0
Huntlyburn	REDACTED	REDACTED	0
Kelso	REDACTED	REDACTED	0
DME 14	22	REDACTED	REDACTED
MAU	REDACTED	0	0
Hawick	REDACTED	REDACTED	0
MAU, Wd 7, Wd 4, DME 14	15	0	0
Ward 4 (2 separate incidents in same ward)	8	0	0
Ward 7	REDACTED	0	0

Summary table of COVID-19 clusters

- ***E.coli* Bacteraemia**

10.3 A PAG was convened on 20th September 2023 following identification of two cases of hospital acquired *E.coli* bacteraemia within DME 14 which occurred in July 2023 (delay due to obtaining results from reference laboratory). Sequencing results identified that these cases could be linked, however direction of transmission is unknown therefore we are unable to establish index case.

10.4 Patients were cared for in separate bays so there was unclear mechanism for transmission. IPCN visited the ward to review equipment and commodes with no significant issues identified. One patient sadly passed away with *E.coli* bacteraemia recorded on the death certificate. Review of this case is currently underway with Clinical Governance & Quality.

10.5 Lack of information on the prevalence of this particular strain of E.coli makes it difficult to ascertain significance. There was no significant antibiotic resistance noted for either isolate which could be indicative of an endemic strain.

10.6 There were no ongoing actions or issues identified and the incident was closed following reporting to ARHAI Scotland. There has been no further evidence of transmission.

11.0 Quality Improvement Update

11.1 Due to sickness absence and an upcoming vacancy it has not been possible to progress with quality improvement workstreams. IPCT are currently reviewing priorities to ensure that this work resumes when possible.

11.2 The Prevention of CAUTI group continue to meet and the work plan is being progressed through this group.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information, for each acute hospital and key community hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections *(*also broken down into MSSA and MRSA) and *Clostridium difficile* infections, as well as cleaning compliance. In addition, there is a single report card which covers all community hospitals [which do not have individual cards], and a report which covers infections identified as having been contracted from out with hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers
Clostridium difficile infections *(CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month. *Staphylococcus aureus* bacteraemia (SAB) cases are further broken down into Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Meticillin Resistant *Staphylococcus aureus* (MRSA).

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

Targets
There are national targets associated with reductions in *E.coli* bacteraemia, *C.diff* and SABs. More information on these can be found on the UKHSA website:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1081256/mandatory-healthcare-associated-infection-surveillance-data-quality-statement-FY2019-to-FY2020.pdf

Understanding the Report Cards – Cleaning Compliance
Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website:
http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Understanding the Report Cards – *'Out of Hospital Infections'*
Clostridium difficile infections and *Staphylococcus aureus (*including MRSA*)* bacteraemia cases are associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

NHS BORDERS BOARD REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023
MRSA	0	1	0	0	1	0	0	0	0	0	0
MSSA	1	4	2	3	3	2	3	3	2	1	4
Total SABS	1	5	2	3	4	2	3	3	2	1	4

Clostridioides difficile infection monthly case numbers

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023
Ages 15-64	0	0	0	0	0	1	0	0	1	1	0
Ages 65 plus	0	1	0	0	0	2	0	1	1	2	2
Ages 15 plus	0	1	1	0	0	3	0	1	2	3	0

Cleaning Compliance (%)

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
Board Total	95.6	95.6	95.8	96.7	96.7	95.6	94.1	95.6	92.7	95.5	96.7

Estates Monitoring Compliance (%)

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023
Board Total	97.3	97.1	96.9	96.3	98.0	97.2	98.3	96.9	98.5	97.5	98.3

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
MRSA	0	1	0	0	0	0	0	0	0	0	0
MSSA	0	2	1	1	0	0	1	1	1	0	3
Total SABS	0	3	1	1	0	0	1	1	1	0	3

Clostridioides difficile infection monthly case numbers

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	1	0	0	1	0	0
Ages 15 plus	0	0	0	0	0	1	0	0	1	0	0

Cleaning Compliance (%)

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
BGH Total	95.5	95.5	95.8	95.9	96.6	95.3	95.5	94.7	95.2	95.6	95.9

Estates Monitoring Compliance (%)

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
BGH Total	97.2	97.0	96.3	97.4	97.3	97.3	97.3	96.9	97.3	97.6	97.5

NHS COMMUNITY HOSPITALS REPORT CARD

The community hospitals covered in this report card include:

- **Haylodge Community Hospital**
- **Hawick Community Hospital**
- **Kelso Community Hospital**
- **Knoll Community Hospital**

Staphylococcus aureus bacteraemia monthly case numbers

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0
Total SABS	0	0	0	0	0	0	0	0	0	0	0

Clostridioides difficile infection monthly case numbers

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	0	0	0	0
Ages 15 plus	0	0	0	0	0	0	0	0	0	0	0

NHS OUT OF HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
MRSA	0	0	0	0	1	0	0	0	0	0	0
MSSA	1	2	1	2	3	2	2	2	1	1	1
Total SABS	1	2	1	2	4	2	2	2	1	1	1

Clostridioides difficile infection monthly case numbers

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023
Ages 15-64	0	0	0	0	0	1	0	0	1	1	0
Ages 65 plus	0	1	1	0	0	1	0	1	0	2	2
Ages 15 plus	0	1	1	0	0	2	0	1	1	3	0

2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety

2.3.2 Workforce

Infection Control staffing issues are detailed in this report.

2.3.3 Financial

This assessment has not identified any resource implications.

2.3.4 Risk Assessment/Management

All risks are highlighted within the paper.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Climate Change

None identified

2.3.7 Other impacts

None identified

2.3.8 Communication, involvement, engagement and consultation

This is a regular bi-monthly update as required by SGHD. As with all Board papers, this update will be shared with the Area Clinical Forum for information.

2.3.9 Route to the Meeting

This report has not been submitted to any prior groups or committees but much of the content will be presented to the Clinical Governance Committee.

2.4 Recommendation

Board members are asked to:-

Discussion – Examine and consider the implications of the content of this paper.

3 List of appendices

The following appendices are included with this report:

- Appendix A, Definitions and Supplementary Information

APPENDIX A

Definitions and Supplementary Information

Staphylococcus aureus Bacteraemia (SAB)

Staphylococcus aureus is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is Meticillin Sensitive *Staphylococcus Aureus* (MSSA), but the more well-known is MRSA (Meticillin Resistant *Staphylococcus Aureus*), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat. More information on these organisms can be found at:

Staphylococcus aureus : https://www.nhs.uk/conditions/staphylococcal-infections/

MRSA: https://www.nhs.uk/conditions/mrsa/

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemia. These are a serious form of infection and there is a national target to reduce them. The number of patients with MSSA and MRSA bacteraemia for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemia can be found at:

https://www.hps.scot.nhs.uk/publications/?topic=HAI%20Quarterly%20Epidemiological%20Data

Clostridioides difficile infection (CDI)

Clostridioides difficile is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at:

http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx

NHS Boards carry out surveillance of *Clostridioides difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridioides difficile* infections can be found at:

https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/#data

Escherichia coli bacteraemia (ECB)

Escherichia coli (*E. coli*) is a bacterium that forms part of the normal gut flora that helps human digestion. Although most types of *E. coli* live harmlessly in your gut, some types can make you unwell. When it gets into your blood stream, *E. coli* can cause a bacteraemia. Further information is available here:

https://www.gov.uk/government/collections/escherichia-coli-e-coli-guidance-data-and-analysis

NHS Borders participate in the HPS mandatory surveillance programme for ECB. This surveillance supports local and national improvement strategies to reduce these infections and improve the outcomes for those affected. Further information on the surveillance programme can be found here: https://www.hps.scot.nhs.uk/a-to-z-of-topics/escherichia-coli-bacteraemia-surveillance/

Hand Hygiene

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.

Cleaning and the Healthcare Environment

Keeping the healthcare environment clean is essential to prevent the spread of infections. NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%. The cleaning compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national cleanliness compliance monitoring can be found at:

http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Healthcare environment standards are also independently inspected by Healthcare Improvement Scotland. More details can be found at:

https://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services.aspx

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Public Protection Annual Report**
Responsible Executive/Non-Executive:	**Sarah Horan- Director of Nursing, Midwifery and AHPs**
Report Author:	**Rachel Pulman- Nurse Consultant Public Protection**

1 Purpose

This is presented to the Committee for:

- Awareness

This report relates to a:

- Assurance that NHSB structure and processes are in accordance with national legislation, procedures and guidance.

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The report is being brought to the Board for awareness.

'Everybody in the Scottish Borders has the right to live safe from abuse, harm and neglect' (Public Protection Committee Vision statement)

NHS Borders and the NHS Borders Public Protection team continue to promote the key principle that Child and Adult Support and Protection is 'Everyone's Responsibility'.

Public Protection (PP) practice continues to be emotive, complex and challenging particularly against the backdrop of the economic climate and resource demand

versus staffing capacity. This challenges services to ensure that collaborative partnership working continues to be a critical factor in protecting those at risk of harm, abuse or neglect.

NHS Borders (NHSB) have specific responsibilities and work along with the Scottish Borders Partnership to report progress and ensure evidence of continuous improvement for both Child Protection and Adult Support and Protection.

The NHS Borders Public Protection (PP) team continue to provide specialist and expert public protection advice, support, supervision (key staff) and training to staff across the organisation to support them to fulfil their responsibilities and duties in respect to a wide range of public protection issues across the life span.

The NHSB PP team is committed to ensure that all Public Protection process, particularly in relation to child and adult support and protection are robust and effective and that we are responsive to emerging local and national needs and initiatives. Most importantly we aim to ensure that the person at risk of harm remains at the centre and that their voice is heard and a culture of learning is promoted.

2.2 Background

There are several key pieces of legislation, policy and guidance that outline duties and responsibilities and support the delivery of Public Protection Services including;

Children and Young People (Scotland) Act 2014
Getting it right for every child (GIRFEC)
National guidance for child protection in Scotland
Adult Support and Protection (Scotland) Act 2007
Adults with Incapacity (Scotland) Act 2000
Mental Health (Care and Treatment) Scotland Act 2003
Equally Safe Strategy 2018
Multi-Agency Public Protection Arrangements (MAPPA): National Guidance 2022
PREVENT Guidance 2021
Adult Support and Protection (Scotland) Act 2007 - Code of Practice
National guidance for child protection committees undertaking learning reviews
Guidance for Adult Protection Committees to use when considering or undertaking learning reviews.

Scottish Borders Joint Inspections

Joint Inspection Adult Support and Protection

A significant focus over the last year has been in relation to inspection activity.

Following the positive inspection report for Adult Support and Protection the Scottish Minister for Social Care, Mental Wellbeing and Sport, Maree Todd visited the Scottish Borders Public Protection Unit and met meet with members of the Chief Officer Group; senior managers; frontline managers and staff, and service users. Following the visit The Minister expressed her thanks and commented that;

'The Scottish Borders Adult Support and Protection Inspection report found that the partnership had major strengths in strategic leadership and ASP processes, which in turn

facilitated positive experiences and outcomes for adults at risk of harm. I was interested to hear about the work the partnership has done to merge Child Protection and Adult Support and Protection into a Public Protection partnership approach which, through multi-agency working and co-location, enables a positive culture between senior leaders and staff. As we know, Adult Support and Protection is a vital part of supporting the vision as we work together to improve the lives of people in Scotland. Adults at risk of harm must be at the heart of decisions, and their voices heard when shaping services. In this aspect, Scottish Borders partnership is a shining example of excellent practice.'

The Joint Inspection of Adult Support and Protection Overview report (Aug 2023) only one Partnership Area, Scottish Borders, out of all 25 inspected since the start of the pandemic, were measured as 'Very effective in operational Key Processes' and 'Very effective in Strategic Leadership'. There are several comments in the report directly attributable to Scottish Borders, and we are now cited in national conversations as a best practice example for Scotland by the Inspectorate.

Scottish Borders joint inspection children at risk of harm.pdf (careinspectorate.com)

The aim of the Joint inspection was to provide assurance on the extent to which services in Scottish Borders were working together, to demonstrate that:

1. Children and young people are safer because risks have been identified early and responded to effectively.
2. Children and young people's lives improve with high quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm.
3. They influence service planning, delivery and improvement.
4. Collaborative strategic leadership, planning and operational management ensure high standards of service delivery

The inspectors found 'important strengths that had significant positive impacts on children and young people's experiences' and evaluated 'impact on children and young people' as good.

Strengths highlighted in the report include:

- Children, young people and families benefited from supportive and trusting relationships with staff across services.
- The recognition and initial response to risk and concern to children was a strength. Staff took timely and appropriate action to keep children safe.
- Pregnant women and very young babies received help and support at an early stage as a result of timely referrals from pre-birth services
- Well-established collaborative working across services ensured children and young people benefited from timely responses to identification of risks.
- Nurturing and trauma informed services provided a range of supports to help children and young people recover from abuse, neglect and trauma. Some of these services were not consistently available when children and young people needed them.
- Children, young people and parents and carers were supported to meaningfully contribute to decisions about their lives by compassionate staff.
- Evidence of strong partnership working, and staff and leaders demonstrating commitment to improving outcomes for children, young people and families.

The report also highlighted areas for improvement which include;

- Strengthening quality of chronologies and children's plans.
- Ensuring that the voice of children and families are routinely and meaningfully influenced service planning and improvement.
- Strengthening the partnership's approach to improvement and change to ensure a shared and systematic approach to quality assurance and self-evaluation.

Scottish Borders Partnership have developed an Improvement plan (submitted to Care Inspectorate 04/07/23) that details how the key areas identified will be prioritised to evidence continued improvement. The care inspectorate will offer support for improvement and monitor progress though our linking arrangements.

Work is already underway in relation to the opportunities for improvement including the transition into a new structure with the aim of streamlining strategic groups and to improve connections within the planning structures for Children Services and development of joint quality assurance and self evaluation processes to maximise the impact of services on children and young people.

The positive findings highlighted within both inspection report's reflect the hard work, knowledge and skills and commitment of staff within NHS Borders and across the partnership.

2.3 Assessment

- **Governance, accountability, quality assurance and reporting arrangements for protecting children and adults are in place across the organisation.**

- The Governance, accountability and reporting arrangements for Public Protection in Scottish Borders are place.
- Chief Executives of Health Boards are the Chief Officers responsible for ensuring that their organisation works individually and in partnership, to protect individuals who may be at risk of harm.
- The Chief Executive has delegated responsibility for Public Protection to the Nurse Director; the Nurse Consultant PP is responsible for leadership, co-ordination and management of PP services.
- Nurse Consultant PP advises and escalates any risks regards Child and Adult Support and Protection matters to the Director of Nursing and/or Associate Director of Nursing for the relevant clinical board area.
- There are named professional who have specific roles and responsibilities for Public Protection work; these roles are fulfilled and in place.
- Quarterly ASP and CP performance reports are shared with Critical Services Oversight Group (CSOG) and PPC who provide oversight and scrutiny to key performance indicators. The report considers 5 performance indicators;
    - Involved: Considers the volume of cases involved in the ASP/CP processes. Demonstrates services demand
    - Other services: What Input is provided by different partners
    - Characteristics: Vulnerabilities; the who/where/why. Builds a picture of what is happen within the services.
    - Assessing: Local responses and process effectiveness. Are local and statutory obligations being met.

  - Impact: Measure of impact of the intervention.
- IRD review group: Nurse Consultant PP, Group Manager CP, Inspector Police Scotland and Lead Officer PP review all IRDs to ensure satisfied decision making has been robust and actions completed; also identifies areas for improvement/practice development.
- In response to the publication of the NHS Public Protection Accountability and Assurance Framework 2022 the Lead Nurse's for Child and Adult Support and Protection convened a Short Life Working Group(SLWG) to develop and agree a standardised self-evaluation toolkit to support effective measurements of the public protection arrangements of NHS Boards in respect of Child Protection, Adult Support and Protection and Multi-Agency Public Protection Arrangements. NHSB is involved in a test of change for this project.

PREVENT

Prevent is part of the government counter terrorism strategy- Contest and aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism.

In Scotland, PREVENT delivery is overseen and supported by the Safeguarding and Vulnerability Team (SVT) at the Scottish Government. This team is the point of contact with the UK Government regarding delivery in Scotland and also administers the governance arrangements of PREVENT in Scotland.

Under the Prevent duty, NHS Borders is required to ensure that healthcare workers are able to identify early signs of an individual being drawn into radicalisation (*Process by which a person adopts extremist views or practices to the point of legitimising the use of violence*) and be able to respond and refer appropriately.

Healthcare staff will meet and treat people who may be vulnerable to being drawn into terrorism and as such it is a public protection issue that they must be aware of.

SVT have developed a Prevent annual assurance process and NHS Borders will now be expected to complete an annual return and RAG rate organisational compliance.

Current position of NHS Borders

There is work that needs to be progressed to ensure we are fully compliant with the Prevent duties. NHS Borders submitted first annual return July 2023 (see appendices);

- The Executive Lead for Prevent is Director of HR, OD,OH&S (added to portfolio June 2023) and the Single Point of Contact (SPOC) is the Nurse Consultant for Public Protection.
- NHS Borders PP team provides advice and support for NHS Borders staff who have concerns that somebody is at risk of radicalisation.
- NHS Borders has representation at East Region CONTEST meeting and Prevent SPOC network.
- An NHS Borders Prevent policy is being developed for use across NHS Borders.
- Prevent Multi agency information agreements in place, for reporting concerns and information sharing in line with Child and Adult Support and Protection.

- Currently all NHSB staff complete a Public Protection e-learning module which includes information about PREVENT and links to UK Home Office training.
- There is information available to staff on the intranet Prevent and ASP/CP pages.
- Key staff have attended Prevent Multi-agency Panel Training and Multi-agency links are in place.
- There is a need to revisit staff awareness/knowledge of roles and responsibilities.
    - The current training arrangement does not allow NHSB to capture how many staff complete the UK Home Office training. Going forward assurance is required that staff members are receiving the appropriate level of PREVENT training and are confident in identifying suspected signs of radicalisation.
    - Proposal to be presented to NHSB Training & Education Board, for UK Home Office training module to be added to internal e-learning platform. This will facilitate tracking of staff completing the training. As well as ensuring that all NHSB staff have access to relevant PREVENT awareness training commensurate to their role and responsibility.

National Referral Mechanism

The National Referral Mechanism is a national framework that focuses on improving the identification of victims of human trafficking and exploitation and the support available to help them to safety and recovery.

The National Referral Mechanism (NRM) Toolkit for First Responders in Scotland was commissioned to improve the formal identification of victims through the National Referral Mechanism in Scotland and ensure that both frontline staff and potential victims are clear on the process and possible outcomes of this national pathway to identification and protection.

The Scottish Borders Partnership, including NHSB, has been involved in a NRM implementation pilot to evaluate the structured implementation of the toolkit for First Responder agencies in Scottish Borders by providing a framework linking strategic leadership to frontline practice and protocol development. Outputs include:

- A structured action plan detailing key steps in the implementation of the NRM Toolkit including key communication and engagement with stakeholders.
- Identification of a First Responder team within the Public Protection Unit.
- Development of locally agreed Human Trafficking Protocol including NRM process/flowchart.
- Tiered training including First Responder training on the use of the NRM process to support effective referrals.
- Wider workforce awareness sessions on Human Trafficking and locally agreed protocols.
- Suite of guidance documents to support and effective response to human trafficking in Scottish Borders to include interagency guidance/quick guides and briefings.

There have been three Human Trafficking Awareness sessions delivered, to support staff to recognise, respond and report concerns; 45 key staff across NHSB have attended.

- **NHS Borders is committed to identifying and responding to concerns about children and young people and Adults and has systems in place that direct staff to the actions they need to.**

- Child Protection and ASP policies, protocols and guidance are up to date and accessible to all staff, on NHSB Borders Intranet, to support them in the responsibilities they have for protecting children and adults.
- There is clear information about how to make a child and/or ASP referral on the intranet and how to seek advice/consultation.
- There are processes in place to enable Specialist Medicals and Health Assessments for Children and YP.
- The Lead paediatrician for Child Protection, who is responsible for Child Sexual Abuse Examinations(CSE), is on extended leave and during this period cover in relation to these duties is being provided via NHS Lothian.

- **There are strategic and operational arrangements in place between NHS Borders and multiagency partners to improve joint working and communication regarding children and young people and adults across agencies; think family.**

- The NHS Borders PP team continue to contribute to the operational and strategic functioning of the Multi-Agency Public protection Unit.
- There is a Public Protection Communication Delivery group that ensures a coordinated approach to the dissemination of key information to ensure a consistent approach to messaging.
- Staff from the Health and Social Care Partnership, including staff from public protection services, attended a workshop in May to discuss the development of a Capacity Pathway. This followed work undertaken to review and update the partnership's existing Capacity Assessment Tool (CAT). The aim of the workshop was to develop a Capacity Pathway across NHS and SBC and to jointly agree a flowchart and improved system of progressing Capacity-related situations in hospital, at home and in situations which require intervention under formal Adult Support & Protection. NHSB is progressing a parallel piece of work to develop a pathway of referral once it has been assessed that a Medical Assessment of Capacity is indicated.
- A Multi-Agency Short Life Working Group(SLWG) has been established to progress work in relation to strengthening chronologies, analysis and professional curiosity with Child and Adult Support and Protection Processes as per CP and ASP Improvement plans.
- NHSB are represented on a number of Multi-Agency strategic and operational groups in relation to Public Protection Practice.
- A Multi-Agency SLWG has been established to review current data collection processes and establish a consistent approach to reporting, Joint self-evaluation and practice development.
- A multi-agency group of staff from the Public Protection Unit have been reviewing the revised National Child Protection Guidance along side our current Scottish Borders CP Procedures to identify what changes are required to ensure we align with the updated guidance and are now progressing to writing the new version of the Scottish Borders Child Protection Procedures and creating an implementation plan. The main areas for change are in relations to:
    - Use of terminology
    - Changes to timescales for some meetings and associated reports

- Improvements to the role of core group

As we progress with writing the content, we will be talking to front line practitioners from across all agencies about specific aspects, to make sure we get it right.
NB: The current CP procedures remain fully operational.

- **NHS Borders PP team ensure the establishment and maintenance of robust information sharing processes and procedures with regards to child and adult protection;**

There are established information sharing processes in place to share information in relation to Public Protection.

- A new alert process has been introduced on EMIS and Trac to flag to staff when an Adult or Child is subject to a CP or ASP investigation.
- Processes are in place to ensure that appropriate, relevant and proportionate information is shared in relation to MAPPA nominals.

NB: The number of different patient management systems in place across NHS Borders presents a challenge in ensuring relevant and proportionate information is shared/documented across all these systems.

- **NHS Borders has arrangements in place that provide support and supervision to staff working with vulnerable children, young people and families.**

- NHSB Public protection team continue to provide consultation for staff on Child and Adult Support and Protection matters.
- Child Protection Supervision is available and accessed as per child protection supervision policy.
- Child Protection Supervisor training (x2 Day/March 2023) was commissioned and delivered by an external trainer to **16** staff across health visiting/school nursing and Midwifery Service. This has supported us to develop skilled supervisors and enables us to continue to develop a consistent approach and understanding of what constitutes effective child protection supervision and its relationship to safe practice and positive outcomes for children and adults.

- **NHS Borders will ensure that Training and Development opportunities are available and accessible to support staff to fulfil roles and responsibilities for Public Protection.**

- NHSB is committed to promoting a learning culture that ensures that gaps in protection services and systems, which may adversely impact on the outcomes for children, YP and adults are identified and addressed.
- Systems are in place to deliver single and multi-agency training on Public Protection across NHSB.
- Mandatory Public Protection e-learning module August 2023 **80.8**% compliance for completion.
- NHS Borders staff across a broad spectrum of disciplines attended Multi-Agency Public Protection Training.

Developments from audit and practice reviews

A Case review in 2022 identified that there was a need to strengthening early recognition and response to vulnerability and risk pre-birth across midwifery services.

Actions

- Learning from review was shared with midwifery staff and training was delivered to Midwives specifically about identifying and responding to risk in ante-natal period.
- Attendance by PP team at team meeting liaison with Associate Director of Nursing for MW.
- A pre-birth section for the keeping children safe and well tool was developed and introduced to support assessment of risk (This tool is guidance to support all agencies to gauge appropriate levels of support and protection using 'stages' that correspond to the 4 Staged Model of Support); evaluated well by midwifery staff.
- SOP developed for Health Visiting and Midwifery service when non-engagement or unseen; particularly in relation to home visit (linked to HV pathway visit). This ensures that HV and/or MW will see and assess home environment in antenatal period.
- NHS Borders Unseen Child Policy updated to include unborn child.
- Pre-Birth Multi-Agency oversight group (includes Midwifery, CP/PP Nurse, Family Nurse, Duty SW team leader)- has oversight of all referrals made to Children and Families Duty Team and ensure that referrals have progressed and/or that appropriate assessments and plans are in place also ensure timescales are being met. Recently introduced review at 24 and 32 weeks.

Impact:

- Increase in timely referrals from midwifery service in respect to concerns pre-birth. When initial referral is made a date/invite is also provided for an initial pre-birth MAC. This increases opportunity to gather information, make assessment of risk and inform planning with women and families.
- **Referrals made by midwifes** 2019 -16 2020-34 2021-45 2022-46.
- Improvement in documentation and referral information on Badgernet.
- Increased use of Child Protection consultation by midwifery service.

There is still work ongoing to continue to strengthen pre-birth assessment and planning processes across multi-agency partners to ensure that assessment and planning commence as early as possible, this includes the development of 'Multi-Agency Pre-Birth Guidance'

Learning from other Board Areas

We have used learning from a Significant Case Review in another area of Scotland for an infant who died from traumatic brain injury to review our own internal processes. This included;

- Reflective learning session with Health visitors and midwives and paediatric nursing teams. Consultant Paediatrician also gave a learning session to Doctors.
- Feedback from staff was that the reflective session made then consider their own practice and assessments. Particularly re how fathers are included.
- Development of SOP for measurement of OFC and management of colic
- Messaging to parents re management of crying baby

Learning Reviews and Large Scale Inquires

A Multi-Agency Learning Review Delivery Group (sub-group of PPC) has been established to ensure that there is robust governance in respect to the commissioning and embedding from Learning Reviews.

There has been two Multi-Agency Learning Reviews, in respect to Adult Support and Protection cases, requested and approved by the Public Protection Committee**.** An external reviewer has been commissioned to undertake one and the other will be undertaken by a reviewer within SBC.

There has been one Large Scale Investigation commenced in Jul 2023.

2.3.1 Quality/ Patient Care

See with above content

2.3.2 Workforce

The current team continues to work at capacity which impacts on the ability to respond to aspects of work such as quality assurance, training and practice development versus the need to meet operational demand. There are also wider influences on the multi-agency response to Child and Adult Support and Protection in relation to the service demands and recruitment challenges our social work colleagues are facing.

The work of public protection is emotive and at times upsetting and disturbing as such it is important that, as a team, we take time to reflect and acknowledge this in our day to day and are mindful of each other's wellbeing as a team.

2.3.3 Financial

There is no additional budget other than allocated to PP posts.

2.3.4 Risk Assessment/Management

The economic climate and changes in the way we deliver PP services have resulted in increased demand on current workforce. Workforce discussions are on-going with DoN to ensure we continue to deliver safe and effective service responses to PP.

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Climate Change

N/A.

2.3.7 Other impacts

PP operates within a series of complex adaptive systems, many of which continue to experience change as a result of changes in legislation and national guidance and the impact of societal changes.

2.3.8 Communication, involvement, engagement and consultation

N/A.

2.3.9 Route to the Meeting

Clinical Governance Committee.

2.4 Recommendation

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

- The Underpinning message is that Child and Adult Support and Protection is everyone's business irrespective of role or position in NHS borders.

3 List of appendices

Appendix No 1, PREVENT Annual Assurance Return 2023

4 Glossary

- ASP- Adult Support and Protection
- CP- Child Protection
- YP- Young Person
- MAPPA- Multi-Agency Public Protection Arrangements
- PP- Public Protection
- CSOG- Critical Services Oversight Group
- PPC- Public Protection Committee

PREVENT Annual Assurance Return Questions 2023 – Health

The PREVENT Duty under the Counter-Terrorism and Security Act 2015 requires all specified authorities to have "due regard to the need to PREVENT people from being drawn into terrorism". Your sector and their partners have a core role to play in countering terrorism and helping to safeguard individuals at risk of radicalisation and are therefore essential to the success of the programme.

National security and counter-terrorism are reserved functions, and as such the PREVENT Duty is established by the UK Parliament who oversee delivery in Scotland. However, the functions responsible for the delivery of PREVENT in Scotland are all devolved. As a result of this, there is a key role for Scottish Ministers who are consulted with regard to statutory guidance for PREVENT and in holding to account and supporting devolved functions in the delivery of PREVENT, despite the Scottish Government not being a specified authority under the Act.

In Scotland, PREVENT delivery is overseen and supported by the Safeguarding and Vulnerability Team (SVT) at the Scottish Government. This team not only is the point of contact with the UK Government regarding delivery in Scotland, but administers the governance arrangements of PREVENT in Scotland and provides support for practitioners across all specified authorities in Scotland.
Your input is essential to ensuring PREVENT is delivered appropriately by assessing local risk, supporting successful interventions through PMAP, building trust with communities, and ensuring sectors are aware of how and when to make a referral. Sharing best practice across sectors – whether via regional networking events, PREVENT governance structures, written communications/ newsletters - has been vital to the continuous improvement of delivery, helping practitioners share innovative projects, unblock barriers to success and reduce the risk of radicalisation in our communities. To extend this drive for continuous improvement, SVT have developed a PREVENT Annual Assurance Process. By now, you will have already completed the PREVENT Assurance Toolkit for your sector. The second phase of this assurance process is the completion of this PREVENT Annual Assurance Return.

The purpose of the initiative is to: illustrate what successful PREVENT delivery looks like; identify good working practice; proactively identify risk and areas for improvement; improve the quality of feedback to all sectors; and enable us to tailor our support throughout the year to sectors. We recognise the need to be thoughtful and considerate when conducting this work. Local barriers, resources, competing priorities and what constitutes as a proportionate response to risk are all important factors to consider when any assessments are conducted.

When completing this form, you will be asked to RAG rate your organisations level of compliance. Where your response is 'Green' please use the text box to detail examples of good working practices within your organisation. Where you select 'Amber' or 'Red' to the question, please use the text box to state any areas identified where additional focus may be required.

Examples of areas of good practice have also been highlighted in asterisks. These are areas which we believe would be beneficial for sectors to have in place but are not stipulated within the PREVENT Duty Guidance. Please use this area to detail any good working practices you have implemented within your organisation.

Senior sign off on this assurance statement is required for your organisation. This will confirm that this document provides an accurate assessment of compliance with PREVENT requirements for the financial year 2022/23.

Please note, return date for this form is 19th June 2023.

If you have any questions regarding this form, please email catherine.anderson@gov.scot

	GREEN	AMBER	RED	COMMENTS
Key area of Focus 1- Leadership				
1) There is active engagement from the Chief Executive and corporate senior management team with the range of PREVENT partners including Police.			x	The Director portfolios have recently changed, and a meeting is being arranged with relevant staff to discuss PREVENT.
2) A PREVENT Single Point of Contact (SPOC) has been appointed for the Health Board. This lead understands what is entailed in and has capacity to perform this role, and SVT have been provided with their name and contact details.			x	The PREVENT lead/SPOC for NHSB has recently retired. The meeting above will re visit and agree governance structure/roles and responsibility within NHSB going forward. Interim information Re SPOC available on NHSB PREVENT intranet page. Once roles decided, works will commence to ensure a greater awareness of role of SPOC across services (link to training).
3) Health Boards' arrangements for delivering PREVENT effectively link into those in place for child and adult protection. Chief Executives liaise with their Local Authority counterparts and advise Chief Officers of the local Health and Social Care Partnerships how to discharge the duty on their behalf and to report on performance.		x		Established processes in place. Chief Executive/New Director arrangements to be confirmed. There is information on NHSB intranet and within procedures regarding how to escalate CP/ASP concerns within NHSB and when concerns need to be raised with external agencies.

				There is a specific PREVENT NHSB intranet page, this will need refreshing by the new Director. PREVENT responsibilities are linked to into those in place for Child and Adult Protection although there are opportunities to further develop this. PREVENT Guidance and procedures are in place, which are complied with, re CP and ASP adults and available on the intranet.
4) In view of their responsibilities for prison healthcare services, it is expected that the Health Board Chief Executives will inform prison governors of their PREVENT plans and fully engage prison healthcare staff in relevant training and development activities.	x			Not applicable NHSB does not have any prisons within the region.
5) A strategic sector lead for your sector is an active member of the PREVENT sub-group. The health SPOC is aware of who this strategic sector lead is and engages with them as necessary in the first instance for advice or guidance on any PREVENT related concerns and provides relevant updates to be fed into the Sub-Group by the strategic sector lead on their behalf.	x			NHSB has representation at - East Region CONTEST meeting - PREVENT SPOC Network
6) *Additional good practice* Is the SPOC engaged with networks as a means of obtaining support for PREVENT delivery? Eg SPOC network, signed up to Knowledge Hub.	x			Current NHSB SPOC attends Health SPOC network
Key Area of Focus 2- Training				
1) Where there are signs that someone has been or is being drawn into terrorism, NHS staff are trained to recognise those signs correctly and are aware of and can locate available support, including making a referral, when necessary via their Health Boards PREVENT SPOC. The Health SPOC ensures that all relevant (frontline and non-frontline) staff are aware of their duty with regard to PREVENT.		x		Currently all NHSB staff complete a Public Protection e-learning module which includes information about PREVENT and links to UK Home Office training. The current training arrangement does not allow NHSB to capture how many staff complete the UK Home Office training.

				Going forward assurance is required that staff members are receiving the appropriate level of PREVENT training and are confident in identifying suspected signs of radicalisation. Proposal to be presented to NHSB Training & Education Board, for UK Home Office training module to be added to internal e-learning platform. This will facilitate tracking of staff completing the training. As well as ensuring that all NHSB staff have access to relevant PREVENT awareness training commensurate to their role and responsibility. Alongside this a training implementation plan will be developed that details which staff need to be trained on PREVENT.
2) *Additional good practice* Have you developed a training plan detailing what staff need to be trained on PREVENT and are linked into ongoing training/refresher opportunities for training for new and existing staff?			x	As above
Key Area of Focus 3- Referrals				
1) Where there are signs that someone has been, or is being drawn into terrorism, NHS staff are aware of the referral process within the health board and know to make a referral via their Health Board PREVENT SPOC.		x		There is information available to staff on the intranet PREVENT and ASP/CP pages. There is a need to revisit staff awareness/knowledge of roles and responsibilities.

2) *Additional good practice* Does your health board have the PREVENT SPOC's name and details and referral form on the organisations internal staff system? Are staff aware that it is there and know how to complete it?		x		Information on Intranet. Need assurance that staff aware and know how to complete it
Key Area of Focus 4- Information Sharing				
1) Staff understand how to balance patient confidentiality with the PREVENT duty. They know from whom they can get advice and support on confidentiality issues when responding to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment. There are procedures both internally and externally for sharing information about vulnerable individuals (where appropriate to do so) in line with the Counter Terrorism Security Act 2015 which should be used as the basis of information sharing. This includes information sharing agreements where possible and/or deemed necessary.	x			PREVENT Multi agency information agreements in place, for reporting concerns and information sharing in line with Child and Adult Support and Protection.
Key Area of Focus 5- Partnership				
1) The Health Board demonstrates that they are engaged with a local Multi-Agency group and additional PREVENT groups where appropriate, to agree and coordinate PREVENT activity based on a shared understanding of the threat, risk and vulnerability in the area.	x			NHSB has representation on various groups
2) The Health Board has a PREVENT Action Plan agreed and in place with the actions reflected in the implementation plan. The action plan makes reference to existing policies, procedures and protocols.			x	Draft Policy in place awaiting approval by new Director before commences consultation period.
3) There are mechanisms for exception reporting to the PREVENT sub-group and for performance reporting to the NHS Scotland Chief Operating Officer who will represent NHS Scotland on the Strategic Contest Board for Scotland (SCBS).			x	An agreed process to be developed and added as an appendix to the policy
Key Area of Focus 6- Monitoring				
1) The Health Board has put appropriate arrangements in place to monitor the delivery and performance of their PREVENT Action Plan and any impact on other duties.			x	As above
Key Area of Focus 7- Commissioning and Procurement				
1) The PREVENT Duty is covered in contracts and grants made with and to any organisation (including private and voluntary agencies) performing a relevant function on the Health Board's behalf. The health boards procurement team are aware of their responsibilities under the PREVENT Duty.			x	Await instruction from new Director

Key Area of Focus 8- PMAP				
1) The Health Board is 'PMAP ready' in the instance that a PMAP panel is established and their membership at that panel is required. The health SPOC is aware of who their local authority PREVENT SPOC and PMAP chair is.	x			Key staff have attended PMAP training. Multi-agency links in place.

……

Chief Executive: NHS Borders

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Public Governance Committee Minutes**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Public Governance Committee with the Board.

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Public Governance Committee 2023 9 November 2023

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Public Governance Committee minutes 10.08.23

PUBLIC GOVERNANCE COMMITTEE

Minutes of Public Governance Committee (PGC)
Meeting held on Thursday 10th August 2023 10.00am
via MS Teams

Present: Tris Taylor, Non Executive Director (Chair)
Lucy O'Leary, Non Executive
Cllr David Parker, Non Executive
Margaret Simpson, Ability Borders
Graham Hayward, Vice Chair, Public Involvement Partnership Group
Heather Fullbrook, Borders Carers

In Attendance:
June Smyth, Director of Planning & Performance
Karen Hamilton, Chair NHS Borders
Carol Graham, Public Involvement Officer
Sharon Bleakley, NHS HIS, Engagement Programme Manager
Sohail Bhatti, Director of Public Health
Lettie Pringle, Risk Manager (deputising for Laura Jones)
Lisa Clark, Clinical Nurse Manager
Kirk Lakie, General Manager for Planned Care
Kirsty Kiln, Public Health, Action CPH
Andy Carter, Director of Workforce, OHS & OD
John McLaren, Employee Director
Susan Cowe, Quality Improvement Facilitator - Person Centred Care
Marion Phillips, Committee Administrator

1. Welcome & Introductions

Tris Taylor welcomed everyone to the meeting.

The meeting was recorded for purpose of minutes.

2. Apologies & Announcements

Apologies had been received from C Oliver, L Jones, C Wilson

The Chair thanked the Committee for their attendance. Karen Hamilton, Chair of NHS Borders attended as part of her annual programme and as an interested observer of the public governance process.

The Chair advised that the meeting was quorate.

3. Minutes of Previous Meeting:

The minutes from meeting held on 15th June 2023 were approved as accurate.

4. Matters Arising and Action Tracker

Action 45: Adult Changing Facility, June Smyth updated that following discussions at BET, it was suggested it may be something that can be taken forward through Community Planning Partnership to pursue this with an update to be brought to the Endowment Committee but noting that due to capital team commitments such as MRI Scanner and Forensic Suite, it may not progress this financial year.

Graham Hayward commented that there is only one facility available in the Borders, in Galashiels, with another being considered for Jedburgh.

Karen Hamilton offered to take this forward with CPP to ask what the overall strategy is for supporting people with the particular need and how to take this forward.

Cllr Parker commented that new council buildings are required to have a changing place in them, but some of the recent builds had the planning approved before this was a requirement. There are couple of community/private sector organisations who are looking at grant funding to create a changing space. He also asked if a space was previously identified in the BGH then can this be reclaimed for this purpose.

Tris Taylor requested that an update to understand the prioritisation process in Estates be brought to the next meeting to appraise if the process is disadvantageous and iniquitous. June Smyth to speak with Andrew Bone to arrange this.

Actions 62, 63, 64 and 68 are complete

There were no matters arising for discussion

The Committee noted the action tracker and matters arising.

5. Public Governance Business Items

5.1 Chairs Update

Tris Taylor noted that an internal audit of Community Engagement is to be carried out looking at Acute, Mental Health and Community Services. Once the terms of the audit have been finalised they will be circulated to the committee for information.

Tris Taylor reported that all relevant items are already included within the agenda for the meeting and will be discussed as they arise.

The Committee noted the update

5.2 IJB Audit Committee Update:

As discussed on the Action Tracker, Tris Taylor and Lucy O'Leary, Chair of IJB, will discuss what effective arrangements can be put in place regarding the reports.

The Committee noted the update

5.3 Public Involvement & Engagement Update

June Smyth reported on this item, stating that the report gives an update on the activities that have taken place over general public engagement activity. It highlights the meetings that are supported by the team and the pieces of work that the expertise around public engagement and involvement has helped support.

An engagement exercise is outlined in the report, this is linking into the NHS Borders Medium Term plan which is being presented at the Extraordinary Health Board meeting in August. The exercise will be launched at the NHS Annual Review and is planned internally with staff, community and wider public and will be setting out some of workforce and financial challenges being faced as a Board. There will be focused conversations where service changes are likely to be required and introduced as part of medium term planning. It is taking the high level strategic aims and the strategic framework that the Board, IJB and Health & Social Care have adopted and going into more detail to outline some of the challenges being faced and some of the opportunities for change. Allowing communities to get involved in those conversations around more specific services moving forward.

The Public Involvement Pillar is progressing, with the drivers being highlighted and which links into the involving people framework. The framework was formally approved at the last NHS Borders Board meeting. This will be used to measure engagement activities against going forward.

NHS Borders have been invited by Health Improvement Scotland Community Engagement to be involved with testing improvements in assuring service change and will be participating in this piece of work.

Sohail Bhatti acknowledged the amount of work that has gone into these exercises and need to look at the impact and measurable outcomes of the activity. This should be the next stage of the strategy to work out how to do that and should be trying to see how behaviour has been changed or modified as a result of intervention.

Sharon Bleakly asked if there are service changes that the HIS team are kept aware in-line with the Planning with People Guidance and to keep the service change advisor advised.

Carol Graham commented that at the last Public Involvement Partnership Group meeting one of the big key areas discussed was overspend and were open and honest with all public members about this. The Finance Director has been asked to attend the next Public Involvement meeting to give an overview of the financial planning and provide a breakdown of the spending. Tris Taylor informed the group that we need to clear and specific about financial planning in the future at the Time for Change engagement session.

The Committee noted the update.

5.4 Terms of Reference

June Smyth had circulated these to the Committee and all comments received were noted and the Terms of Reference updated. A final version will be sent to the Board Secretary for the Code of Corporate Governance and will circulate a copy to the Committee.

Lucy O'Leary would like to propose that the Committee meet in person at least one meeting per year. Tris Taylor agreed and suggested perhaps the next or following meeting should be in person.

Tris Taylor suggested to have a development session about roles and responsibilities of the members of the Committee. Could this be linked into 'the Voice' training to help define the role of public representative rather than an individual. This also to be held in the next or following subsequent meeting. Margaret Simpson agreed it would be good to share an update on 'The Voice' training.

The Terms of Reference to come back in one year for annual update.

The Committee noted the update.

6. Monitoring & Performance Management

6.1 Clinical Board Updates:

Public Health:
Apologies received from Fiona Doig report to be deferred until next meeting

Mental Health:
Lisa Clark reported that Psychology held a conversation café with people with lived experience about how people are supported who have a diagnosis of emotional unstable personality disorder. There has been some consultation on the single point of access which has been created for the Community MH Teams, a 3 day workshop was held and included people with lived experience. There has been engagement with the Community MH Team looking at a peer support network collaborative in Scotland and again involves people with lived experience.

Lisa commented that there has been public involvement and a Champion's group involved in the development of a SOP for perinatal group. Service Reviews are planned for Mental Health and public involvement will be required as per the Terms of Reference. The Older Adult Services review will take place in September and will update on this at the next meeting.

Sohail Bhatti commented that more evidence is required to demonstrate what has been agreed and achieved within the participation groups. It was noted that MH were using an older template for their report and the updated one to be sent to them.

Primary & Community Services:

Nicola Macdonald reported that P&CS have been using the new Equality & Human Rights Impact Assessment paperwork for the Hospital at Home service. Nicola added that there has been extensive input and engagement and liaison with different groups including staff and third sector partners. The feedback received has helped to shape the service and change patient leaflets etc, this will continue to be reviewed. As this is a new service it is still in a test of change period and the next steps is to seek feedback from specific groups such as money worries groups, LGBTQ, Gender reassignment etc.

Nicola commented that P&CS are looking to involve and integrate Community District Nursing Teams and teams that work in similar areas within Hospital at Home to give it a more equitable feel. P&CS will continue with the public and stakeholder involvement in the test for change to allow for best service possible.

Margaret Simpson added that the Hospital at Home is good service and their subgroup that is involved have been really supportive of it. The EHRIA is being done with Wendy Henderson at the service user groups, which brings the Third Sector and NHS working together.

Acute:

Kirk Lakie reported that although there is ongoing engagement work it has not been fed back and he gave a brief update on the ongoing review of Emergency Care service, Neurology and Women & Children's Services. The engagement with the Women & Children's services has been more problematic but are using the Public Involvement and Engagement team for advice on how to get more people engaged in the work being undertaken.

Kirk commented that work is being commenced on Waiting Well and Acute are working with the Public Health team to help scope what is required and are engaging appropriately with various groups, an update will follow in due course.

Kirk agreed to have a conversation with Laura Jones as the Quality and Governance Lead to look if there is anything specifically to do around patient reported outcome measures. He noted that this is important when talking about a context that includes a requirement to operate within 90% of the financial envelope. Kirk to liaise with Margaret Simpson about sending articles for the newsletter from Acute in relation to the financial challenges facing NHS and the work that is ongoing.

June Smyth to discuss with Executive Directors involved in Acute what the approach is to make the desired level of change in culture to be able to receive meaningful reports on activity evidence.

HIS Community Engagement:

Sharon Bleakley highlighted within the submitted report, the service change workshops and the range of workshops that the service change team provide around service change related topics. Sharon noted that there a lot of service reviews ongoing at the moment which could have implications and highlighted the Judges and Principles workshop and also mentioned that the Planning with People, guidance and planning and Effective Engagement are being merged together. Sharon enquired whether the Committee might be interested in as part of the ongoing development, and offered to have conversation with any teams if they require a specific workshop that might be of help of benefit and can be tailor made from 30 minutes to full 3 hours. June Smyth agreed to promote the workshops internally as the more people that can access them then the richer the engagement will be through service change.

Sharon noted that HIS Community Engagement directorate is in the midst of significant organisational change and there will be structure changes once this is completed. Sharon reiterated that their role as critical friend will still be valid and will provide support while the engagement function is being carried out although it may be carried out slightly differently, an update will be provided at the next meeting.

June and Sharon to have a conversation regarding presentations for non-execs around the duties and principles and also the implications of not carrying them out.

Tris Taylor commented that overall it would be useful if Clinical Boards could start to record the demographics, metrics, and outcomes in more detail if possible. This would provide evidence that engagement is being executed in equitable fashion to fulfil statutory obligations on inequalities and equalities.

The Committee noted all the updates

6.2 Health Inequalities Update / Assurance

The deep dive on inequalities has been deferred until the next meeting.

7. Equalities Mainstreaming Report:

Kirsty Kiln, John McLaren and Andy Carter attended the meeting for this item. Tris Taylor gave some content that the report had gone to the Board who sent it back to this Committee for due governance.

Kirsty reported that the work contained in the report was put together with contributions from HR, Occupational Health and Public Health. It meets the obligation required to demonstrate how the equalities duty within the organisation are applied. Kirsty added that for subsequent iterations of the report it needs to be more collaborative across the organisation and a SLWG will be set up to include staff groups as well as HR, OHS and PH to ensure it is a more engaged process.

Andy Carter reported that taken into consideration is the demography of the workforce which is compared to Scotland census data and look for patterns of success. There has been tremendous success with international recruitment in last 18 months with 65 staff including from India, United Arab Emirates and North Africa. NHS Borders race and ethnicity has changed quite substantially which is good to see. Also, looking at applicants with disabilities coming into the workforce, who disclose that they have a disability, although these figures are low some positive action is being taken on this. He mentioned working with Project Search, who are helping people with learning issues get into work, as well as looking at different ways to get work experience into the workplace.

Andy mentioned that a quarter of the workforce have signed up for the Pride Pledge and badge. Inhouse training is delivered around the compassionate leadership programme along with training on race and equality with an external consultant and LGBTI training is commissioned with the Equality Network Scottish Transgender Alliance. The Once for Scotland HR Polices and are fairly applied in NHSB. The Staff Governance Committee is kept informed against the 5 standards around staff being well informed and treated fairly and provided with a safe environment.

Tris Taylor referred to the 2019 Equalities Mainstreaming report and the recommendations picked up by the external audit, which was then picked up by the Audit Committee, these were to be addressed and reported in the 2021 Equalities Mainstreaming report but these are not mentioned in the report. Tris to forward these recommendations onto Kirsty, John and Andy. Tris commented that he would not be content with the report being published until these and other issues were addressed. +

Margaret Simpson commented that there used to be a Joint Equality Action group within NHS Borders and it helped disabled people get into work, it would be good to get the message out for people to hear rather than pointing to a website full of reports.

Heather Fullbrook raised about carers in the workforce but there is no carers policy and there is no mention of veterans who are classed as a protected part of the population.

Kirsty Kiln acknowledged that there is some information missing and a robust process needs to be in place to allow the report to be more meaningful and there is a need to get the equalities agenda on a sustainable footing throughout the organisation.

Tris Taylor noted that the Committee would be unable to approve this report until they can see the version that Kirsty referred to that should have been forwarded. The Committee needs to be satisfied that there is a systematic approach that will deliver content on outcomes and genuine performance information in time for the next report, an assurance information system around inequalities and then to receive evidence into that system and that it is progressing. The deadline date for publishing the report has passed and Tris said if a new date is set prior to the next meeting in November then happy to receive the report virtually for approval or bring it back along with an assurance information system first iteration while letting the Committee understand what can be logged at this meeting as evidence of performance.

The Committee noted the report

8. Patient Experience

Susan Cowe reported on the main points and that the number of complaints decreased in April, but they increased again in May and June with July looking much the same. The response times decreased in June due to 2 members of staff being absent, but this should pick up again next month.

There has been feedback from complainants regarding the 20 working day extension deadline being sent to them that they would rather be informed that the process would take 2 or 3 months at the beginning. This would set their expectations as they find it upsetting getting the extension around the time it is due and causing more anxiety. Susan noted that recently this has been changed and patients are now being informed that it is taking an average of 40 days for a response, but more complex complaints will take longer and the patient is informed if it is going to take longer than the 40 days.

Graham Hayward enquired if the report considered when patients are transferred or taken over to another hospital including private ones. Susan responded that while it does consider some of the private ones where their care has been passed on but not the other health boards where they have been referred onto. Graham added that for patients being sub-contracted somewhere else there needs to be understanding that they are being well looked after. June Smyth to have a conversation with Laura Jones regarding patients who have to travel for treatment to other hospitals and where it should sit.

The Committee noted the update

9. Any other business

No other business was raised.

10. Next Meeting Date – Thursday 9th November 10am via MS Teams

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Area Clinical Forum Minutes**
Responsible Executive/Non-Executive:	**Kevin Buchan, Non Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Area Clinical Forum with the Board.

2.2 Background

The minutes are presented to the Board as per the Area Clinical Forum Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board as per the Area Clinical Forum Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Area Clinical Forum 3 October 2023

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Area Clinical Forum minutes 15.08.23

NHS Borders - Area Clinical Forum

MINUTE of meeting held on

Tuesday 15 August 13:00 – 14:00
Via Microsoft Teams

Present: Dr Kevin Buchan, Chair
Rachel Mollart
Alison Wilson
Philip Grieve

In Attendance: Olive Herlihy
Morag Muir

Lesley Shillinglaw – Minutes/Actions

Apologies: Nicky Hall, Gerhard Laker, Caroline Cochrane, Paul Williams, Karen Hamilton, Martin O'Dwyer,

Note meeting not quorate however due to ministerial visit discussion, meeting will go ahead. Noted no formal decisions can be made.

In Attendance:

Olive Herlihy, Morag Muir

1. APOLOGIES and ANNOUNCEMENTS

Paul Williams (Alison Downie deputising), Caroline Cochrane, Martin O'Dwyer, Gerhard Laker, Karen Hamilton, Nicky Hall

2. Draft Minute of previous ACF

Minutes approved as a correct record.

Action Tracker/Matters Arising:

Amendment to Action re SGPC Minutes – share highlights not minutes due to confidentiality - noted

3. Ministerial Annual Review

KB has drafted a document and sent to PMO as well as setting an agenda. Kevin will circulate document when finalised by PMO. Lesley will email out to ascertain who will be attending face to face on 11th September 2023 for Ministerial Visit (Michael Matheson) and inform PMO.

4. **Training for Associates (Olive Herlihy in attendance)**

Kevin welcomed Olive Herlihy to the meeting. Olive Herlihy as below:

- Alliance with Aberdeen University and train under graduate physician associated.
- This year small number in Aberdeen.

- Rotate around various specialties, e.g. ED, Psych and Medicine and surgery however they do not rotate to small specialties obs & gynae.
- In first year regional monies invested into students, giving bursaries – employed 2 due to our own financial constraints – one employed into Acute and one into Psychiatry

- In terms of future employment there is significant interest however financial constraints is issue.

- Need to invest in education and support for future.

There followed discussion as below and the undernoted points were raised.

Kevin Buchan referred to the status in general practice – lots of data collection however difficulty on how take this forward and asked if better being in a setting where there is a constraint and linearity?

In response to Kevin Buchan's query above, Olive Herlihy indicated that Associates do have training in General Practice, however Aberdeen don't have many General Practices to send people to for training therefore this is very limited. She further noted that the practice in medicine within within general practice is different to that within an Acute setting, however support is still required.

Fiona Sandford referred to workforce challenges and asked from a financial point of view, rather than thinking of them as "extra" we could perhaps look at skills mix e.g. ward 12 or other sites where they are unable to recruit enough trained nurses, however could substitute in some way and change skill mix somehow or develop links with Newcastle if wish to expand the programme. In response, Olive referred to a Lead for Physician Associates leading clinically to set up a programme of Education. It was noted however they are not GMC registered yet. In addition, skill mix could be looked at e.g. nursing however difficulty is funding issue. In terms of supervision, this could be an ANP or Senior Nurse or work with medical students. For next year's intake, suggest at look at some training in general practice, along with an ANP.

Kevin Buchan Plan referred to a plan for an "ANP style training school" agreed with Director of Nursing and agreed by NHS Borders.

Kevin thanked Olive for her helpful update.

FS: Reference to Ministerial visit – good news story – Kaisen, Johnathon Antropus work, Discharge Kaisen – looking at changing skills mix bu providing multidisciplinary training for Physician Associates.

5. **Dental Oral Health Plan (Morag Muir in attendance)**

(Report attached for ease of reference)

Kevin welcomed Morag Muir to the meeting and asked the Committee to introduce themselves to Morag. Alison Wilson joined the meeting at this juncture.

Morag gave an outline on the current work on a strategic plan for oral health and dental services with the undernoted highlighted points of note:

- Needs assessment completed – Covid hit big impact on dental services. Now back to Needs Assessment – very much need for Strategic Plan.
- Started by revisiting Needs Assessment.
- Ageing Population
- Oral health has improved
- Increase in dependency – difficult to get to dentists.
- Consult in Autum/Winter – ready to start in April. Keen to have feedback as people who live and work in Borders as well as professionals and links with primary care.
- Attended P&CS Clinical Board.
- Noted - Other groups seeing dental emergencies presenting to them? Dental access has become more challenging.
- Plan still in draft process therefore any thoughts, feedback/issues to raise into Draft Plan welcomed, thereafter the plan will be disseminated more widely to receive feedback.

There followed discussion and Rachel Mollart referred to Primary Care and the slow rise in presentation of dental issues and noted that emergency treatment would be useful to be included in the Strategy. In response, Morag Muir highlighted that indeed, dental problems should be seen by dentists and that antibiotics prescribed by GPs are a temporary measure. It was noted that dental services have seen the number of unregistered patients presenting for emergency care risen drastically. In addition, to note there is dental enquiry line which is first point of call for unregistered where triage of patients and guidelines on how soon a patient should be seen. Furthermore, If a patient is registered with a dentist then first point of call would be their own dentist and the Dental enquiry line will re-direct patients to their registered dentist. Morag Muir informed ACF members that since 2010 we have had “life long registration with general dental practitioners. If a dentist reduces their NHS commitment, then patients can be de-registered and noted the difficulty in registering currently with a dentist. Note there is an Emergency Dental service.

Fiona Sandford indicated that there is a dental update being presented at Clinical Governance meeting today and referred to the up and coming Annual Review and raising the issue around the current negotiations on payment should be highlighted at that forum. Morag Muir indicated that it is helpful now to have the new Dental payment model which will come into effect from November has been published.

In conclusion, Morag Muir intimated that the Strategic Plan will cover the next 12 years and the beginnings focus on difficult situation and accessing dental care. The Plan is also looking ahead to the future around how to develop dental services further with the focus on oral health improvement and preventative measures.

Alison Wilson indicated from a pharmacy perspective that she was not aware of any increase in the numbers of dental presentations within Pharmacies.

6. **Clinical Governance Feedback**

- Meeting moved from July due to clash with Junior Doctors Strike
- Various inspections and action plans.
- Oral Dental Plan.

- Kaisen on Discharge

In response to a query from Kevin Buchan regarding the process of raising issues to Clinical Governance ACF and how this has gone , Fiona Sanford intimated that Clinical Governance see this very much as a this is a vital part. She further indicated that Clinical Governance has moved to seeing medicine in wider remit and recognising that 90% of medicine happens in the community. In addition, Fiona Sandford intimated she had been in discussions with Karen Hamilton regarding formalisting the reporting structure/pathway to Clinical Governance as well as discussions with Laura Jones regarding the formal reporting structure. It was noted that the report from P&CS provided by Philip Grieve was extremely helpful and well received and one suggestion was perhaps adding an Addendum to that report to include discussion points from ACF. It was noted that currently the reporting line into NHS Board from ACF is the inclusion of ACF Minutes. **Action:** Fiona Sandford/Karen Hamilton to discuss reporting structure/formalising pathway with Iris Bishop, Board Secretary.

In response to the report prepared by P&CS, Philip Grieve indicated the ask for inclusion of a statement/summary of GP submission be included in the P&CS report. Tim Young has provided on this occasion. **Action:** It was agreed that Philip Grieve would meet up with Rachel Mollart outwith ACF to discuss what would be helpful from a GP perspective for inclusion in the Addendum to the P&CS report to Clinical Governance. Philp Grieve welcomed the suggestion of providing smaller highlight reports indicating risks, main issues, what requires to be progressed rather than full pages of every details of the service.

In response to a question from Kevin Buchan regarding the process after which issues are escalated to Clinical Governance and changes are required to take place and how this impacts within Primary Care and Independent Contractors, Fiona Sandford referenced recent paper on the Fragility of GP practice which was escalated from Clinical Governance to NHS Borders and the role of Clinical Governance is to escalate any issues to NHS Board from Clinical Boards, including P&CS which would include concerns of Independent Contractors.

Phiip Grieve intimated that he felt that Clinical Governance was more a "reporting into" mechanism and asked about the decision making function and also made reference to other mechanisms and routes for escalation including risks etc. In response Fiona Sandford stated the importance of differentiating between the Board Executive Team (BET) and NHS Board, indicating that the NHS Board does escalate issues and suggestions for improvement up to Scottish Government,

7. **National ACF Chairs Meeting**

No update. Meeting next week. Will provide bullet point update at next ACFmeeting.

8. **Professional Advisory Committees:**

(a) **Area Dental Advisory Committee (ADC)**

No update provided.

(b) **Area Medical Committee (AMC) & GP Sub Group**

Rachel Mollart gave an update of the main issues discussed at GP Sub as noted below:

- Community Hospital admission policy

- Hospital discharges
- PCIP bundle - supported by Board and IJB

Rachel Mollart gave a brief update from AMC as noted below**:**

- Frustration of Clinicians regarding difficulty in remobilising due to delayed discharges, blocking
- Value Based Medicine – Lynn McCallum planning sessions in September secondary care initially. Important that this is rolled out to Primary Care thereafter as soon as possible.

Action: Rachel Mollart will liaise with Lynn McCallum regarding roll out to Primary Care to ensure more cohesive and whole system approach.

(c) **Area Ophthalmic Committee (AOC) –** Nicky provided an update via email now included within minutes as follows:

- There has been increased use of Optometrists as first port of call for eye problems which is being handled well.
- Alongside this, there is regular use of Pharmacy First which optometrists are finding very useful service.
- The current and past AOC chairs have worked hard to open communication channels with the BGH to aid best patient care while ophthalmology deals with the backlog of referrals exacerbated by the covid pandemic. A representative from the Eye Centre attended our recent AOC meeting to provide an update of their plans and gather information on any issues arising from our end.
- IP qualification is being embraced - the BGH is aiding with clinical experience requirement for those currently doing the course.

(d) **Area Pharmaceutical Committee (APC)**

(e) **Allied Health Professionals Advisory Committee (AHP)**

(f) **BANMAC:** No update provided. Will be rebranded

(g) **Medical Scientists**

(h) **Psychology**

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9. **<u>Issues for Escalation to CG/Board</u>**

- Short Summary on discussion on Training for physician associates and financial implications
- Dental Oral Health Plan going to Clinical Governance

10. **Extra Ordinary Board Papers**: Noted

11. **AOB**

Kevin acknowledged that Alison Wilson is retiring and that this would be her last ACF and thanked Alison Wilson for all her input over the years.

12. **Date of Next Meeting**

11 September – Ministerial Visit – Annual Review

3 October – 1pm-2pm – ACF

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**NHS Borders Performance Scorecard October 2023**
Responsible Executive/Non-Executive:	**Stephanie Errington, Interim Director of Planning & Performance**
Report Author:	**Hayley Jacks, Planning & Performance Officer**

1 Purpose

The purpose of this report is to update the Board on NHS Borders latest performance against the suite of performance measures linked to our Annual Delivery Plan. The scorecard also reports key targets and standards that were included in previous Annual Operational Plans (AOPs) and Local Delivery Plans (LDP).

This is presented to the Committee for:

- Awareness

This report relates to a:

- Annual Delivery Plan / Annual Operational Plan / Remobilisation Plan

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective

2 Report summary

2.1 Situation

The main body of the scorecard sets out performance as at end of October 2023 against the targets from the 2023/24 Annual Delivery Plan (ADP). The report also includes as appendices performance as noted against some previous AOP/LDP measures, for information purposes.

2.2 Background

In 2022/23 Scottish Government moved away from commissioning any further remobilisation plans following the covid pandemic and instead commissioned a one-year ADP aimed at stabilising the system. New targets and trajectories were submitted to Scottish Government as part of the 2023/24 ADP.

2.3 Assessment

We are still unable to meet trajectory targets for Outpatients, TTG, Emergency Care and Mental Health (Psychological Therapies) however summaries for each of these can be found within the scorecard where available updates have been added. At the time of writing, the Mental Health CAMHS targets were unavailable but a verbal update will be provided.

Where services have been able to provide it, narrative is contained within the body of the scorecard, focusing on 2023/24 waiting times trajectories and the 'hot topics' of emergency access standard and delayed discharges.

Following a recent request, Health Protection data is currently being reviewed by Public Health, Planning & Performance and Business Intelligence Services with a view for this to be included in future scorecards.

2.3.1 Quality/ Patient Care

The ADP milestones and trajectories, Annual Operational Plan measures and Local Delivery Plan standards are key monitoring tools of Scottish Government in ensuring Patient Safety, Quality and Effectiveness.

2.3.2 Workforce

Directors are asked to support the implementation and monitoring of measures within their service areas.

2.3.3 Financial

Directors are asked to support financial management and monitoring of finance and resources within their service areas.

2.3.4 Risk Assessment/Management

There are several measures that are not being achieved and have not been achieved recently. For these measures service leads continue to take corrective action or outline risks and issues to get them back on trajectory. Continuous monitoring of performance is a key element in identifying risks affecting Health Service delivery to the people of the Borders.

2.3.5 Equality and Diversity, including health inequalities

Services will carry out HIIAs as part of delivering 2022/23 & 2023/24 ADP key deliverables.

2.3.6 Climate Change

None Highlighted

2.3.7 Other Impacts

None Highlighted

2.3.8 Communication, involvement, engagement and consultation

This is an internal performance report and as such no consultation with external stakeholders has been undertaken.

2.3.9 Route to the Meeting

The Performance Scorecard has been developed by the Business Intelligence Team with any associated narrative being collated by the Planning & Performance Team in conjunction with the relevant service area.

2.4 Recommendation

- **Note** – performance as at the end of October 2023.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

PERFORMANCE SCORECARD

As at 31 October 2023

Month 7

Contents Page

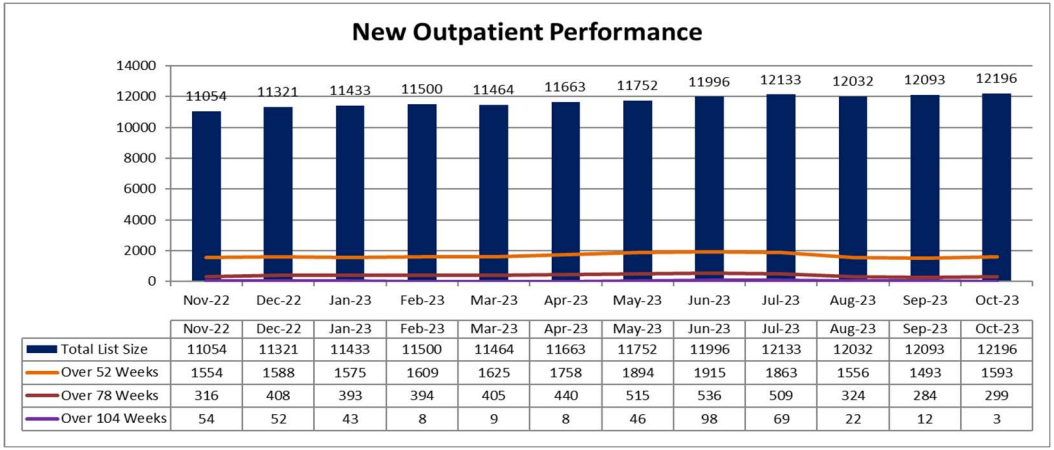
Introduction

As a result of the COVID-19 Pandemic the 2021/22 Annual Operational Plan (AOP) was replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, the latest iteration being RMP4. In 2022/23 Scottish Government moved away from further remobilisation plans and instead commissioned a one-year Annual Delivery Plan (ADP) aimed at stabilising the system. As per the agreed ADP for 2023/24, which was brought to the NHS Borders Board August meeting for approval, all Boards were required to submit waiting times trajectories but no other formal performance measures were agreed.

This report contains the 2023/24 waiting times performance and hot topic measures and an appendix which demonstrates AOP and Local Delivery Plan (LDP) measures (LDPs were in place as performance agreements between Boards and Scottish Government prior to AOPs and we retain some of the performance standards from those plans). In the current report performance is noted against waiting times trajectories in place as at March 2023.

Performance is measured against a set trajectory or standard. To enable current performance to be judged, colour coding is being used to show whether the trajectory is being achieved. A tolerance of 10% is applied to the standards to enable them to be given a RAG status. For standards where the trajectory is 0, the tolerance level is 1, anything higher the RAG status is red (for example waiting times and delayed discharges).

Waiting Time Performance – Outpatient Performance Total List Size by Weeks Waiting



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Total List Size	11054	11321	11433	11500	11464	11663	11752	11996	12133	12032	12093	12196
Over 52 Weeks	1554	1588	1575	1609	1625	1758	1894	1915	1863	1556	1493	1593
Over 78 Weeks	316	408	393	394	405	440	515	536	509	324	284	299
Over 104 Weeks	54	52	43	8	9	8	46	98	69	22	12	3

Fig. 1

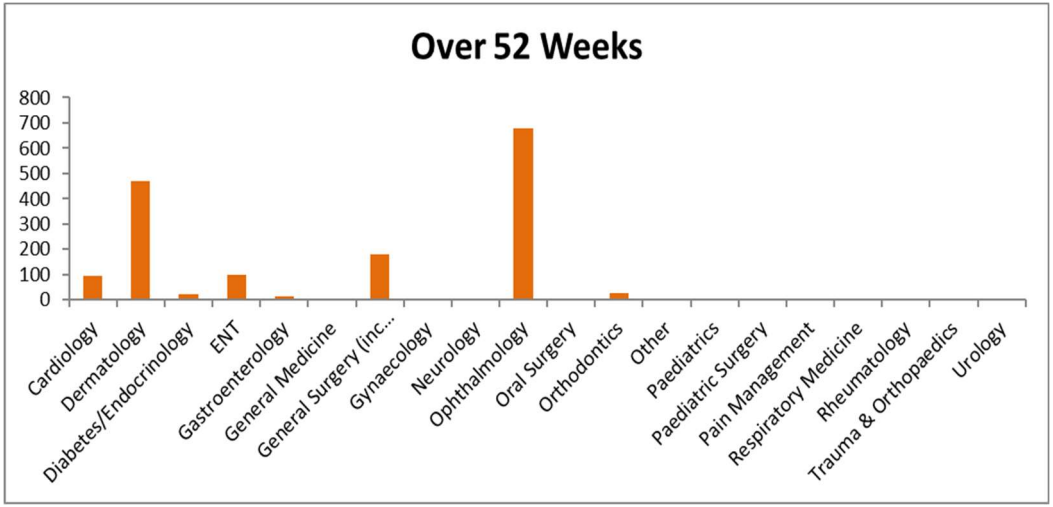


Fig. 2

New Waiting Times Targets ***Updated 28.11.23***

During October the OPD list size has increased from 12093 to 12196. Demand during October was below the predicted level and activity was also below the predicted level.

Current Waiting Times Standard is that no patient should wait over 52 weeks.
We are currently failing to meet the standard where no patient will wait over 52 weeks for their new outpatient appointment. Unfortunately, the number of patients waiting over 52 weeks has slightly increased this month, as has the number of patients waiting over 78 weeks. An analysis of the lost activity against predicted, will be investigated to understand why and put plans in place to recover.

Dermatology – as previously reported we have a new workforce model being developed for longer term sustainability but in the interim we have recruited to 2 temporary medical posts to provide regular capacity, with a potential 3rd coming online in January. We have also secured regular surgical practitioner capacity (via NECU) and the independent sector continue to provide us with capacity two weekends per month. In addition to this capacity, the tele-dermatology pilot has been successful, and this will continue ensuring we are streaming patients to the right service. A full demand and capacity exercise has been undertaken, with early results showing that if capacity is released as predicted, Dermatology will be very close to achieving 52 weeks.

Ophthalmology – the majority of long wait on the outpatient waiting list are cataracts, and as previously reported these patients will be transitioned to the IP/DC waiting list. The team are increasing the number of cataract surgeries performed, and there are plans in place to increase this further by, sustainably increasing the number of cataracts on lists but also increasing operating by one full day per week, commencing in December. This will see an additional 16 patients treated per week.

Process Improvement
The service is making great inroads to standardising and implementing the Centre for Sustainable Delivery (CfSD) endorsed demand management improvements, i.e., ACRT, PIR and Opt In. The table below shows all specialties are actively progressing these improvements.

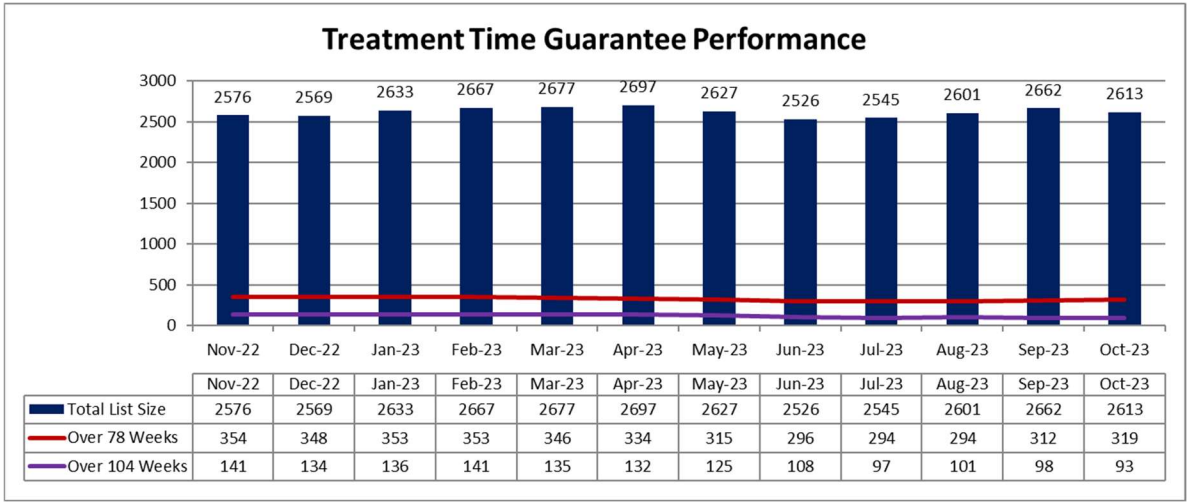
Successes for October

- Further planning of sustainably delivering 8 cataracts
- Testing of Booking Software
- Further resources secured for Dermatology
- Additional capacity for General Surgery & Orthopaedics
- Successful testing of tele-dermatology
- Secured further dermatology capacity
- Successful recruitment to Booking Post

Plan for November

- Plan to in place for 3rd all day list of cataract theatres
- Capacity Planning for specialties and revised trajectories
- Continue with CfSD endorsed improvement opportunities
- Complete OPD matrix to implement via new booking software along with Booking Room SOP
- Identify further opportunities for Opt In
- Realise further capacity from Middle Grade clinics

TTG Performance Against Trajectory- All Specialties



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Total List Size	2576	2569	2633	2667	2677	2697	2627	2526	2545	2601	2662	2613
Over 78 Weeks	354	348	353	353	346	334	315	296	294	294	312	319
Over 104 Weeks	141	134	136	141	135	132	125	108	97	101	98	93

Fig. 3

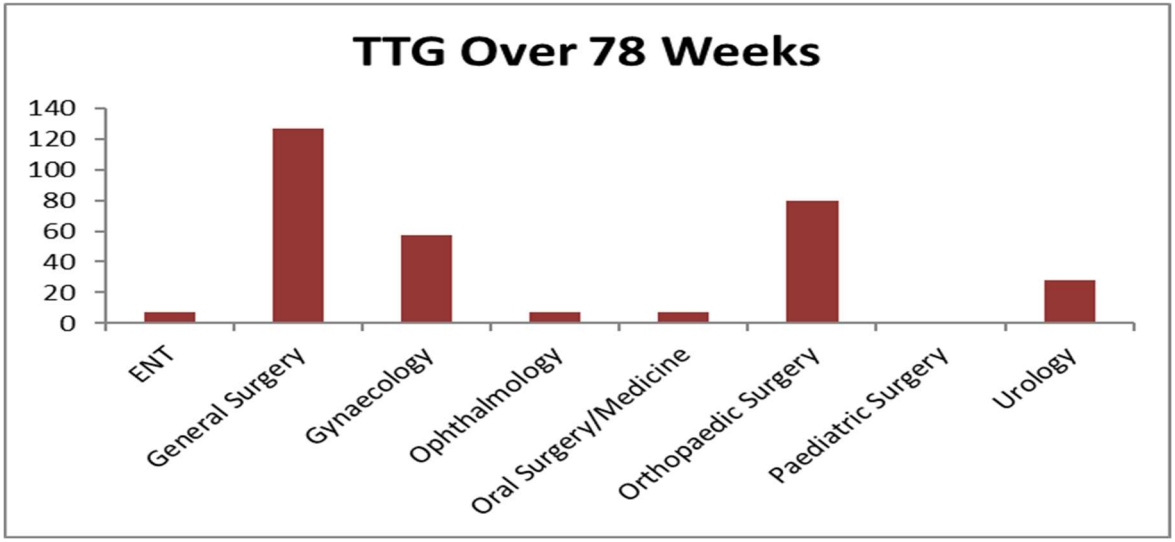


Fig. 4

What is the data telling us? ***Updated 20.11.23***

Waiting Times. The TTG targets for Inpatient / Day Case surgery are as follows:

Theatres:

- 18 month waits for Inpatient / Day Cases in the majority of specialities by end of **Sep 23**.
- 1 year wait for Inpatient / Day Cases in the majority of specialities by end of **Sep 24**.

Chronic Pain:

- 18-week referral to treatment standard.

Performance

October saw increased activity levels compared to September (368 elective operations in October compared to 338 in September), helped by the fact that October was a 5-week month. However, this resulted in 156 elective sessions completed (145 excluding Ophthalmology) which is the highest number since prior to the COVID pandemic.

Actions complete since last report.

- Theatre User Group meetings re-started on November 8. This is the first one since December 2022, with a smaller grouping.
- An additional 4 elective theatre sessions were run in October. This gives the capacity to run 36 elective sessions / week (excluding ophthalmology).
- In addition, the Surgical CMT (Pauline Burns / Grace Brydon and others), moved PSAU from Ward 8 to Ward 17 on 8 November. This will provide additional space to accommodate the increasing numbers of patients who come to BGH for surgery, providing a better patient experience and better process.

Priorities.

- **Theatre sessions Jan – Mar 24** Confirm the number of theatre sessions (not including Ophthalmology) that can be delivered per month from January to March 2024. Dependencies are the confirmation of Theatre Staff capacity and whether IVTs continue to use DPU.
- **Anaesthetic staffing requirement in 2024.** The new Specialty Doctor (SD) 2022 contract specifies that no more than 40% of hours are worked Out of Hours (OOH), unless the individual adopts to work in excess of this figure. The 4x SDs who work for BGH Anaesthetics Department currently work between 60% and 84% OOH. In the next job planning round in 2024 it is anticipated that this could result in a deficit of 71 OOH shifts.
- **NHGJ Travel Costs.** Analyse the spend involved in sending patients to NHGJ and see if / where savings can be made.
- **Elective C-Section numbers.** Set up a process to monitor Elective C-Section demand due to increasing numbers of patients / requirement for theatre space.
- **Chronic Pain Service.** Support has been approved by 'Q' for Sonia Borthwick to support a Service Review into the Chronic Pain Service which is anticipated to start before the end of 2023. This will include a review of how clinical psychology provision can be delivered to the Chronic Pain Service. This position has been vacant since June 2023 and whilst funding has been removed at present, there will be funding available from FY 24/25.

Mental Health Waiting Times - CAMHS

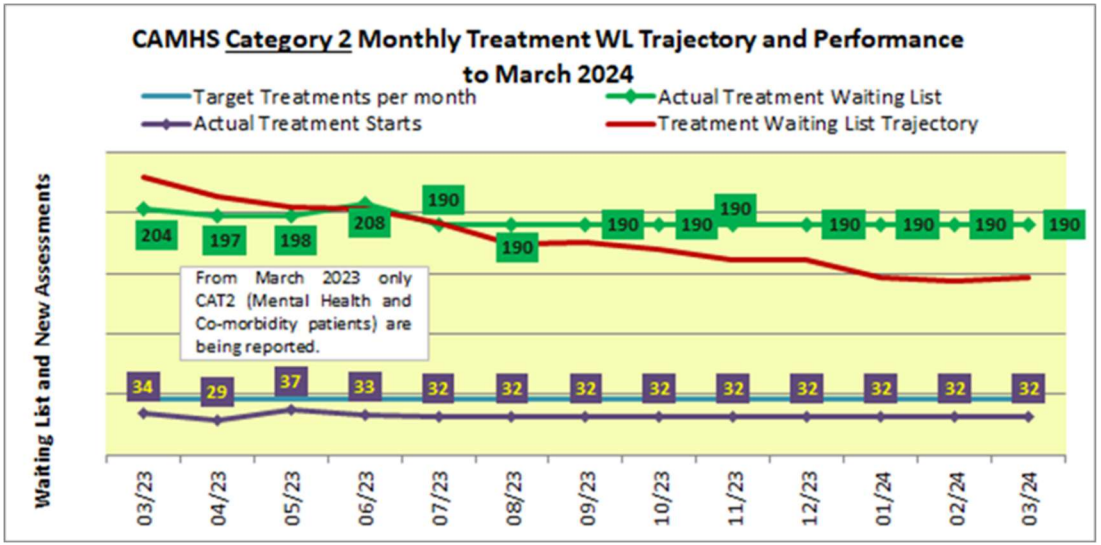


Fig. 5

What is the data telling us? ***Updated 02.11.23***

The waiting list decreases in March 2023 as CAMHS has moved to reporting CAT2 patients only.

There has been a decrease in the total number of referrals for Sept 2023 (66) compared to 72 for August 2023.

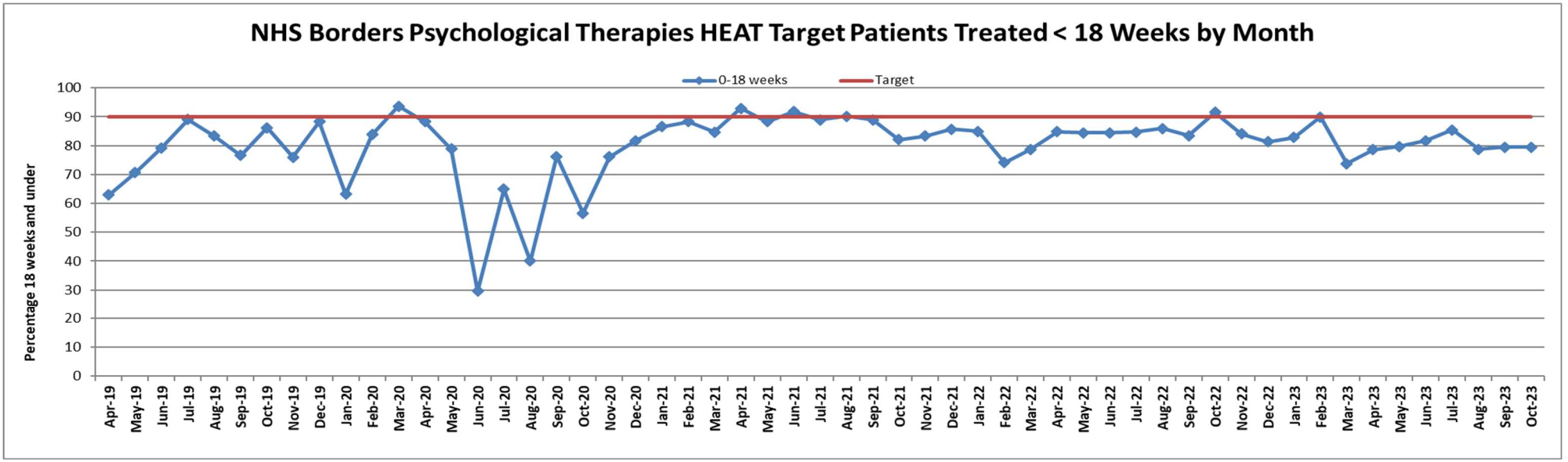
There has been an increase in the number of rejected referrals for Sept 2023 (34) compared to 22 for August 2023. The percentage rejected has therefore increased for Sept 2023 (51.5%) compared to August 2023 (30.6%).

What is being done?

- New Patient Assessments (NPA)
  The service continues with the waiting times initiative of seeing 12 new patients per week. week (included in the 12 appointments, 2 are urgent/unscheduled care appointments) this plan will be in place in order to see a minimum of 12 new patients per week 52 weeks of the year, this will be across all disciplines at this moment in time. The tagging process is continuous and all patients waiting have been tagged as being CAT1 (ND) or CAT 2 (Core mental health) this allows the team to review patients waiting to access the service, with a view to determining appropriate sign-posting or establishing any possible interventions prior to a first appointment.
- School Referral Rollout
  - The pilot was a huge success with excellent quality referrals from the 4 pilot schools for ND patients.
  - We have now rolled out ND referrals to 22 schools in Tweeddale and Eildon West area.
  - The next phase of rolling out to a further 15 schools in Eildon East is about to commence.
- Recruitment
  - Nursing – 2 Band 6 nurses now in post with 2 unfilled posts advertised with 1 application received. There is one Band 6 nurse on long terms sick.
  - Medical staffing vacancy continues and there is still one consultant vacancy, although the service has an additional speciality doctor on a temporary basis and a clinical development fellow for one year.
  - Administration is under a great deal of pressure with the team administrator on long terms sick as well as a team secretary. Along with annual leave. Leaving the admin service with limited resources and having to call on other services to provide additional remote support.
- RHCYP Melville Unit (Royal Hospital for Children & Young People)
  Access to specialist young person beds continues to be challenging placing demands on the adult acute inpatient service. Melville unit is just about reaching 50% staff vacancy level, which needs considered when thinking about the care of our YP.

Mental Health Waiting Times - Psychological Therapies

Fig. 6



Current activity and performance against HEAT Target

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

Performance this month towards the PT RTT standard is largely the same as last month at 79.39 % - last months was 79.47%. In October the service started treatment with 165 patients (151 in September 2023) of which 34 (31 in September 2023) patients had waited longer than 18 weeks for a first treatment appointment (Figure 1).

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

Current PT Waiting List

As at 31st October 2023 we have 645 people on our waiting list, a slight increase of 3 from last month, 91% of whom have waited less than 18 weeks (a slight improvement from last month). We do not have anyone waiting over 52 weeks. We have 10 people waiting in the 35-52 week range which represent 1.6% of those waiting. Waits over 18 weeks are mainly due to capacity issues and delays in secondary care psychology services, especially older adults, learning disability, substance misuse and adult mental health. For those areas which have had an increase in referrals, we are noticing a build-up of assessments, which will most likely impact on treatment waits.

Workforce

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

Updated 27.11.23

Unscheduled Care Performance - 4 Hour Emergency Access Standard Performance

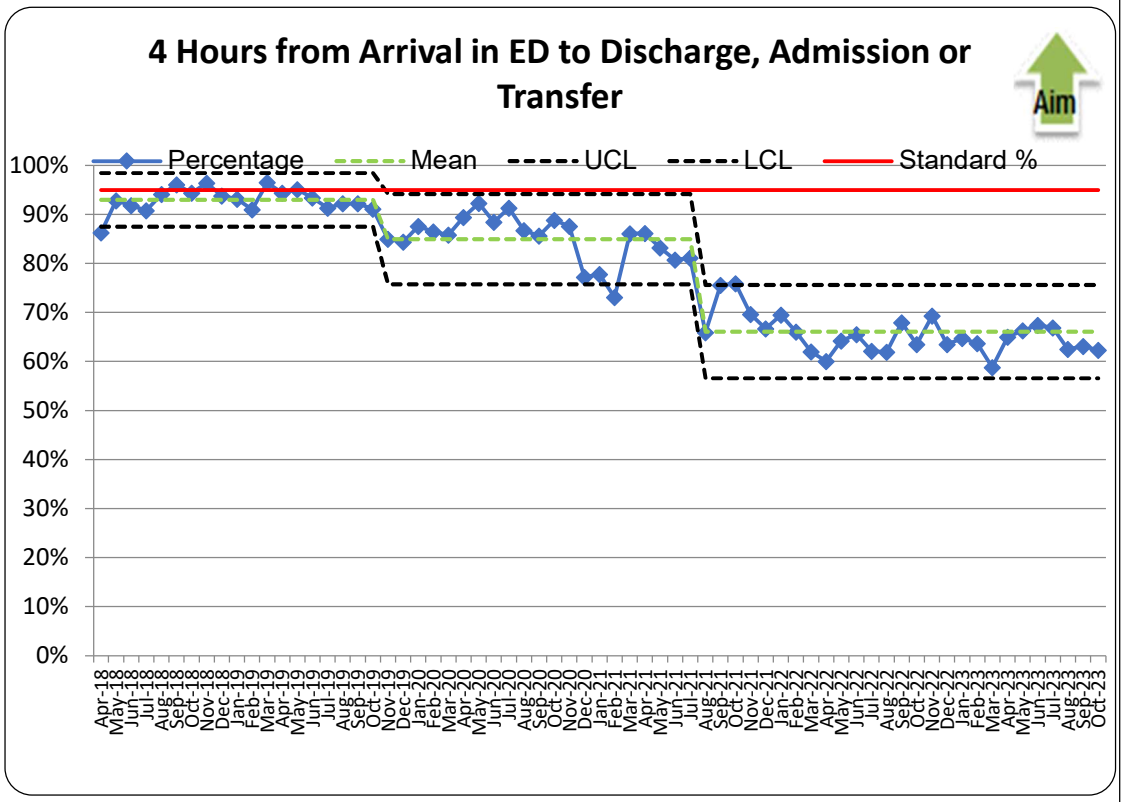


Fig. 7

Updated 27.11.23

The 4-hour emergency access standard ("the standard") is a whole system measure; to either admit or provide definitive treatment and discharge for 95% of unscheduled care patients within 4-hours requires a collaborative approach from all parts of the health and social care system to provide patient flow.

The 4EAS is influenced by a range of factors including, but not limited to:

- the volume of Emergency Department (ED) attendances
- the pattern of arrival of ED attendances i.e., high volumes within a short period causing crowding
- patient acuity
- bed pressures

The Emergency Department continued to see high volumes of waits over 4 hours in September 2023 which was driven by the wider system pressures and translates to the top 3 breach reasons outlined below:

1. Wait for a Medical Bed- 439 Patients
2. Wait for Surgical Bed- 77 Patients
3. Wait for Treatment End- 62 Patients

There were several days within October that recorded a high number of 12-hour breaches. During this month there were 20 instances when 12-hour breaches exceeded 10 and 2 days that saw 24-hour breaches exceeded 10. This is a decline from the previous months performance as shown below:

	Number of Days Where 12 Hours Breaches ≥10	Number of Days Where 24 Hours Breaches ≥10
September	9	0
October	20	2

What is being done?

- Flow- this remains a key priority with the daily 8.30am Safety Brief and 2pm Flow Meeting taking place with key stakeholders from across NHS Borders and our partners such as Scottish Ambulance Service in attendance.
- ED Workforce Review -. This review is now complete and has been supported by BET – it is planned to go to the NHS Board/IJB in due course. If supported, focus will move to developing a comprehensive implementation plan to deliver the required workforce changes.
- Integrated Discharge Without Delay- a group has been established and will take a whole system approach to identify key areas of improvement through parallel and collaborative working with our partner at Scottish Borders Council to implement the principles.
- Winter Surge and Hospital Occupancy Plan – This plan (for delivery over October – March) seeks to gradually close this surge capacity within the BGH in favour of replacing this with substantive capacity within the community. IN doing so, the trajectory for delays in projected to fall from 88 – 22 to March 24.

Delayed Discharge

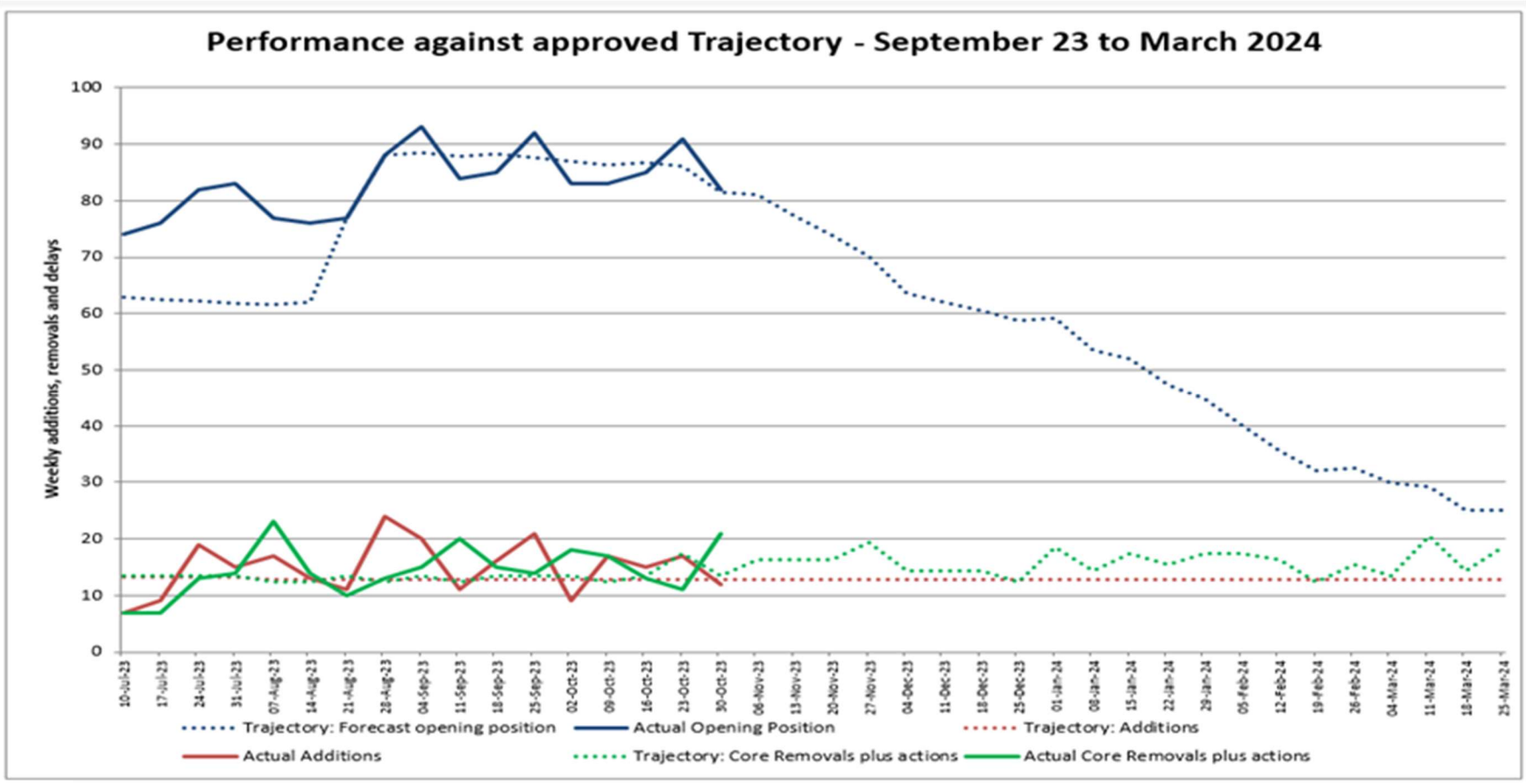


Fig. 8

What is the data telling us?

The data is telling us that delayed discharge performance is currently slightly ahead of the planned trajectory however there has been an increase in the number of additions / referrals over the period compared to our forecast. There has also been an associated increase in removals over the period.

Why is this the case?

Referrals over the period were higher than expected, and removals were also higher than expected. The delivery of removals / transfers to care was broadly in line with our plan, however it is worth noting that there were more people removed due to health reasons than forecast.

When exploring the weeks in which these increased removals took place, it is apparent that in many weeks where there have been increased removals due to ill health, this was associated to increased referrals in the same week. It is expected that this relates to the referral of a number of people who were not fit for discharge, and also a higher denominator of referrals associated to increased acuity, need and dependence. For instance, in the week where this was most pronounced, the week commencing 23/07, there were 19 referrals made (compared to the expected 13.3), and 9 removals due to ill health (compared to the expected 5.3).

15 weeks 10/07/23 - 16/10/23	Referrals	Removals	*Of which, transfer to care*	*Of which, for health reasons*
Total forecast	**193.6**	**196.4**	107.9	88.5
Total actual	**224**	**213**	117	96
VarianCI	**30.4**	**16.6**	9.1	7.5
Forecast - weekly	**12.9**	**13.1**	7.2	5.9
Actual - weekly	**14.9**	**14.2**	7.8	6.4
VarianCI - weekly	**2.0**	**1.1**	0.6	0.5

Fig. 9

What is being done?

The Discharge Kaizen ended on the 31st August 2023, remains in place to consolidate data/information and associated learning and will be presented to the organisation/HSCP in November 2023. The national self-assessment for the implementation of discharge without delay principles was completed in September 2023 and we await the return to progress any associated actions.

The Integration Joint Board issued a direction on surge planning, which includes a range of further measures to alleviate the pressures, including discharge (home to assess), single assessment, closer working with the third sector and communications promoting community supports, which will all help reduce the demand for social work and social care, get more people onto the right intermediate care pathway, and increase productivity.

Increased capacity within social care has progressed with the opening of 39 additional Extra Care Housing units Poynder Apartments in Kelso and continue to see residents move into this facility. The additional residential care step-down and step-up and respite capacity are projected to be in place in October remains on track, along with 9 extra Enhanced Residential rooms in Knowesouth in November, and a further 9 rooms in other settings being commissioned as planned in November. Work continues to progress to develop the approach to the integration of Home First with the Adult Social Care Home Care service, some challenges remain with the progression of this initiative and this is likely to be

delayed into February. A paper on the approach to integration of these services and was presented at the HSCP Joint Executive, and a paper will go to the IJB for consideration in January.

Appendix to Main Performance Scorecard – Performance Against Previous Agreed Standards

Contents Page

Key Metrics Report – AOP Performance

Current Performance Key

R	Under performing	Current performance is significantly outwith the trajectory/ standard set	Outwith the standard/ trajectory by 11% or greater
A	Slightly Below Trajectory/ Standard	Current performance is moderately outwith the trajectory/standard set	Outwith the standard/ trajectory by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory/standard set	Overachieves, meets or exceeds the standard/trajectory, or rounds up to standard/trajectory

Symbols

Better performance than previous month	↑
No change in performance from previous month	↔
Worse performance than previous month	↓
Data not available or no comparable data	-

Key Metrics Report Annual Operational Standards

Measure	Target/ Standard	Period	Position	Period	Position	RAG
Cancer waiting Times - 62 Day target	95% patients treated following urgent referral with suspicion of cancer within 62 days	Aug-23	88.5%	Sep-23	95.2%	↑
Cancer waiting Times - 31 Day target	95% of patients treated within 31 days of diagnosis	Aug-23	96.8%	Sep-23	100.0%	↑
New Outpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Sep-23	7588	Oct-23	7770	↓
New Inpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Sep-23	1658	Oct-23	1682	↓
Treatment Time Guarantee - Number not treated within 84 days from decision to treat	Zero patients having waiting longer than 84 days.	Sep-23	145	Oct-23	149	↑
Referral to Treatment (RTT) - % treated within 18 weeks of referral	90% patient to be seen and treated within 18 weeks of referral.	Sep-23	62.7%	Oct-23	67.2%	↑
Diagnostics (8 key tests) - Number waiting >6 weeks	Zero patients waiting longer than 6 weeks for 8 key diagnostic tests	Sep-23	638	Oct-23	739	↓
CAMHS- % treated within 18 weeks of referral	90% patients seen and treated within 18 weeks of referral	Aug-23	33.3%	Sep-23	40.7%	↑
A&E 4 Hour Standard - Patients discharged or transferred within 4 hours	95% of patients seen, discharged or transferred within 4 hours	Sep-23	63.1%	Oct-23	62.3%	↓
Delayed Discharges - Patients delayed over 72 hours	Zero patients delayed in hospital for more than 72 hours	Sep-23	75	Oct-23	71	↑
Psychological Therapies - % treated within 18 weeks of referral	90% patient treated within 18 weeks of referral	Aug-23	78.8%	Sep-23	79.5%	↑
Drug & Alcohol - Treated within 3 weeks of referral	90% patient treated within 3 weeks of referral	Q1 2023/24	96%	Q2 2023/24	100%	↑
Sickness Absence Rates	Maintain overall sickness absence rates below 4%	Aug-23	5.62%	Sep-23	6.45%	↓

Cancer Waiting Times *(Please Note: There is a 1 month lag time for data)*

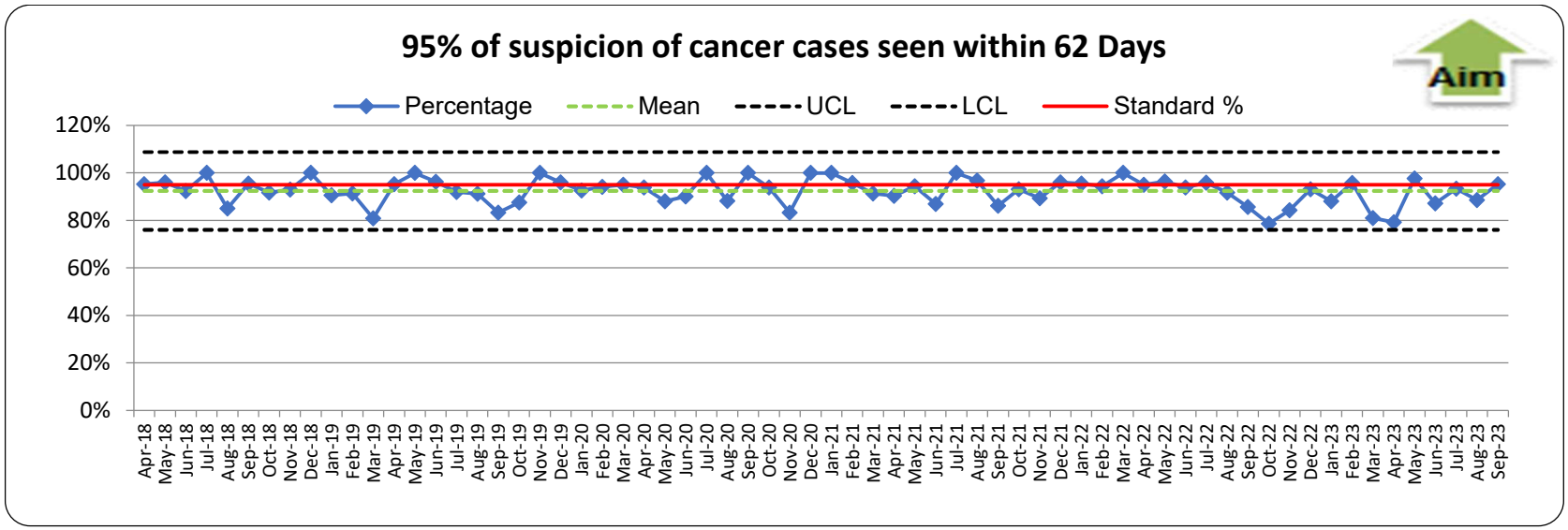


Fig. 10

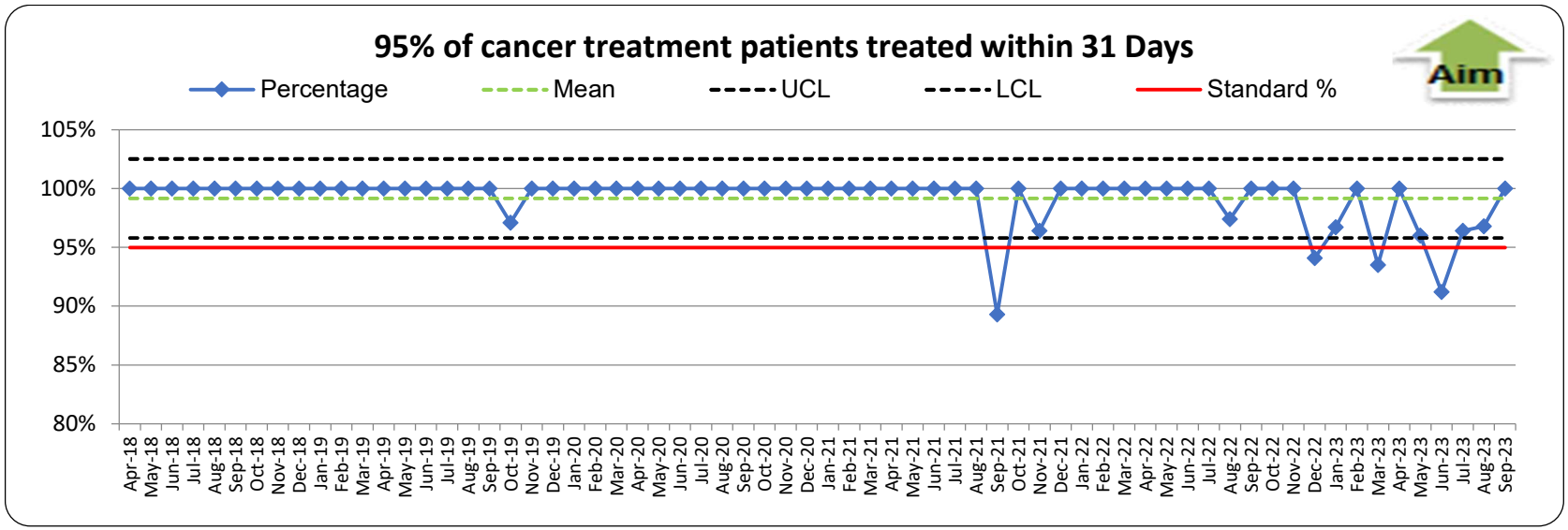


Fig. 11

Stage of Treatment- Outpatients Waiting Over 12 Weeks

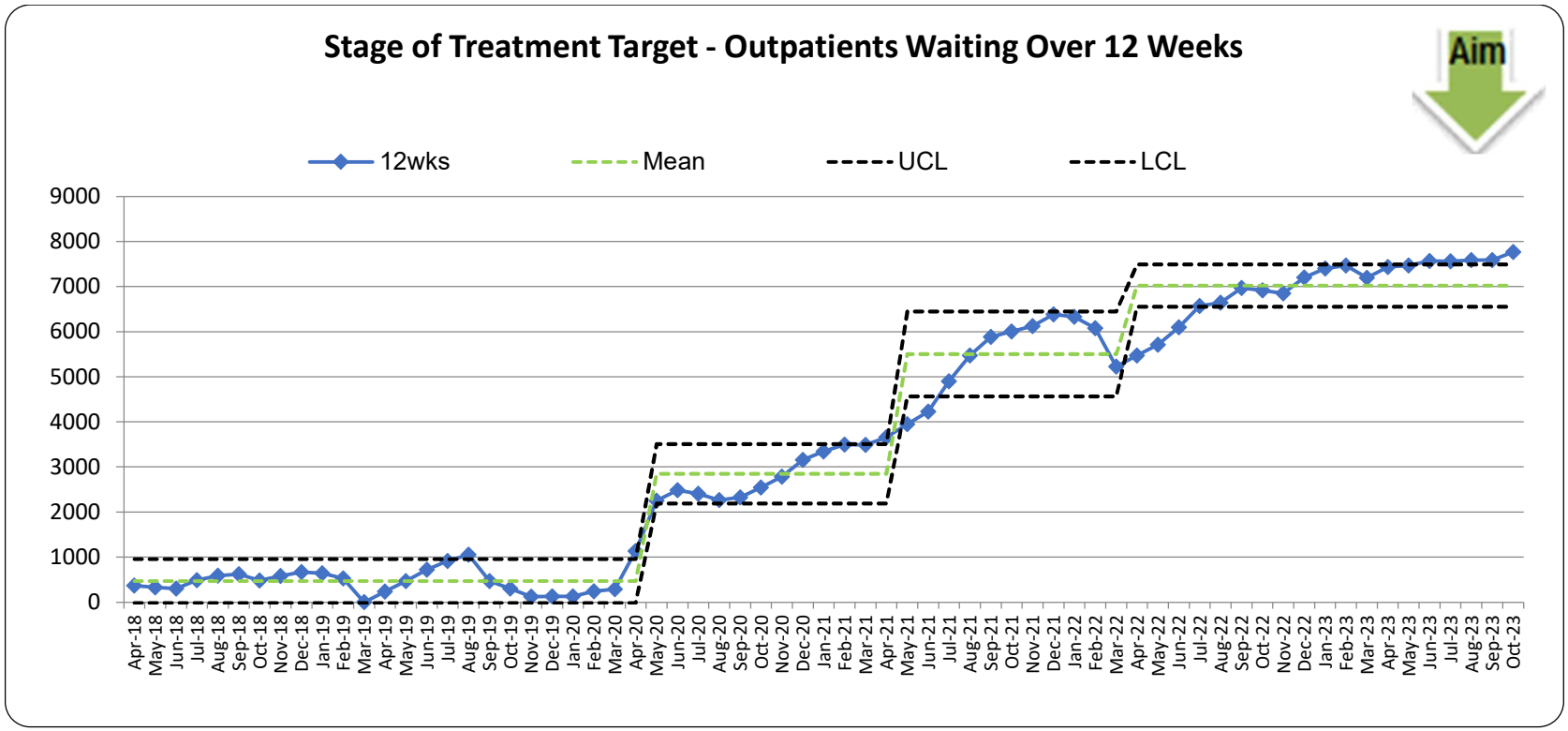


Fig. 12

Stage of Treatment- Inpatients Waiting Over 12 Weeks

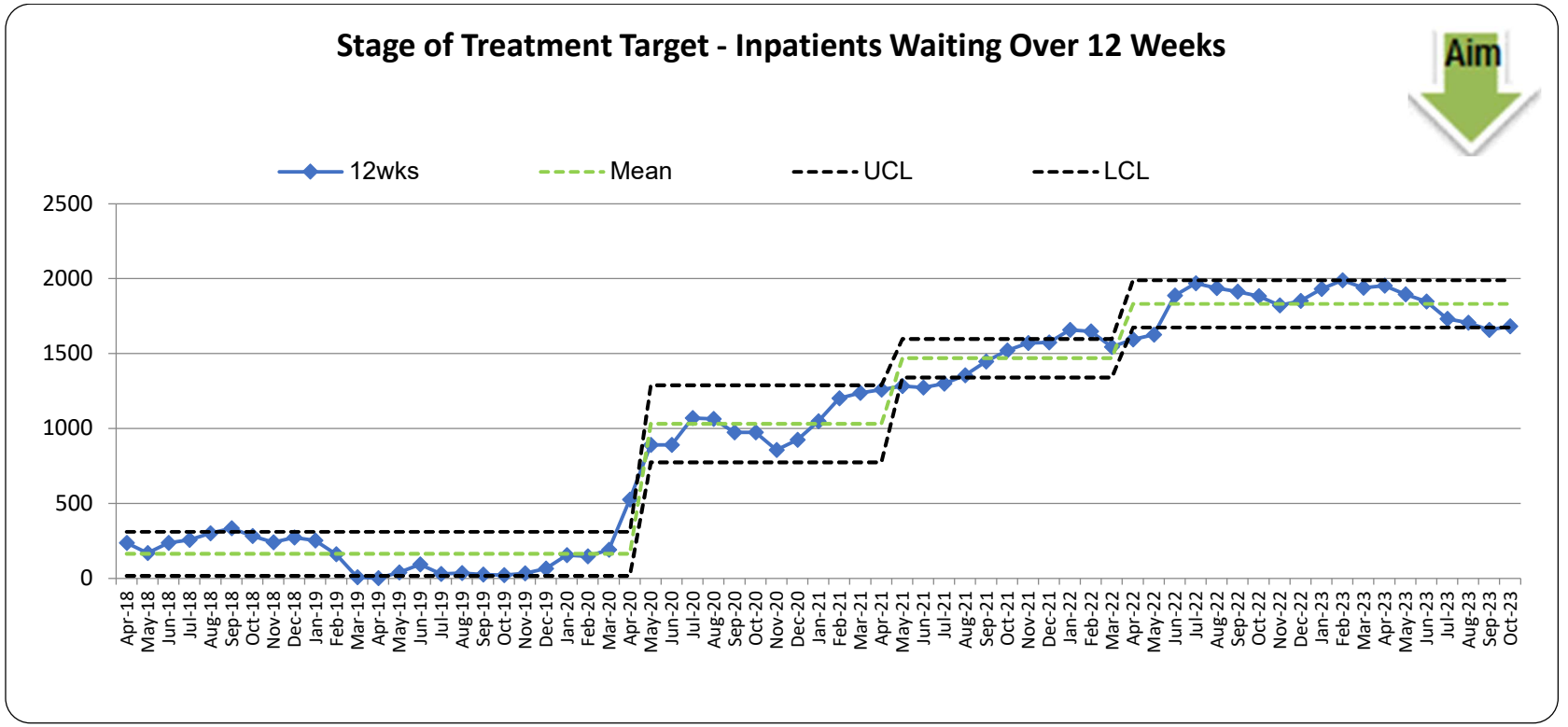


Fig. 13

Patients Treated within the 12 weeks Treatment Time Guarantee

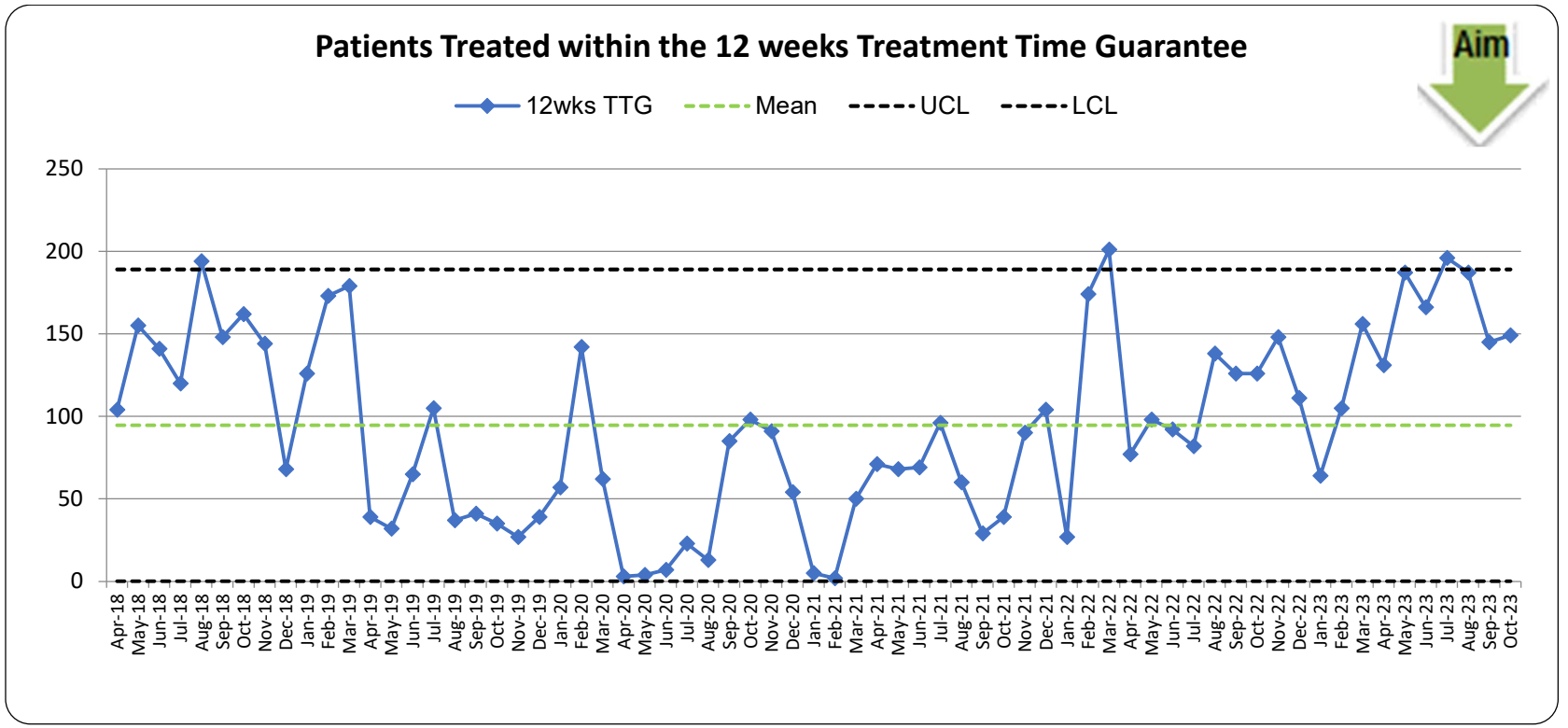


Fig. 14

18 Weeks Referral to Treatment Combined Pathway Performance

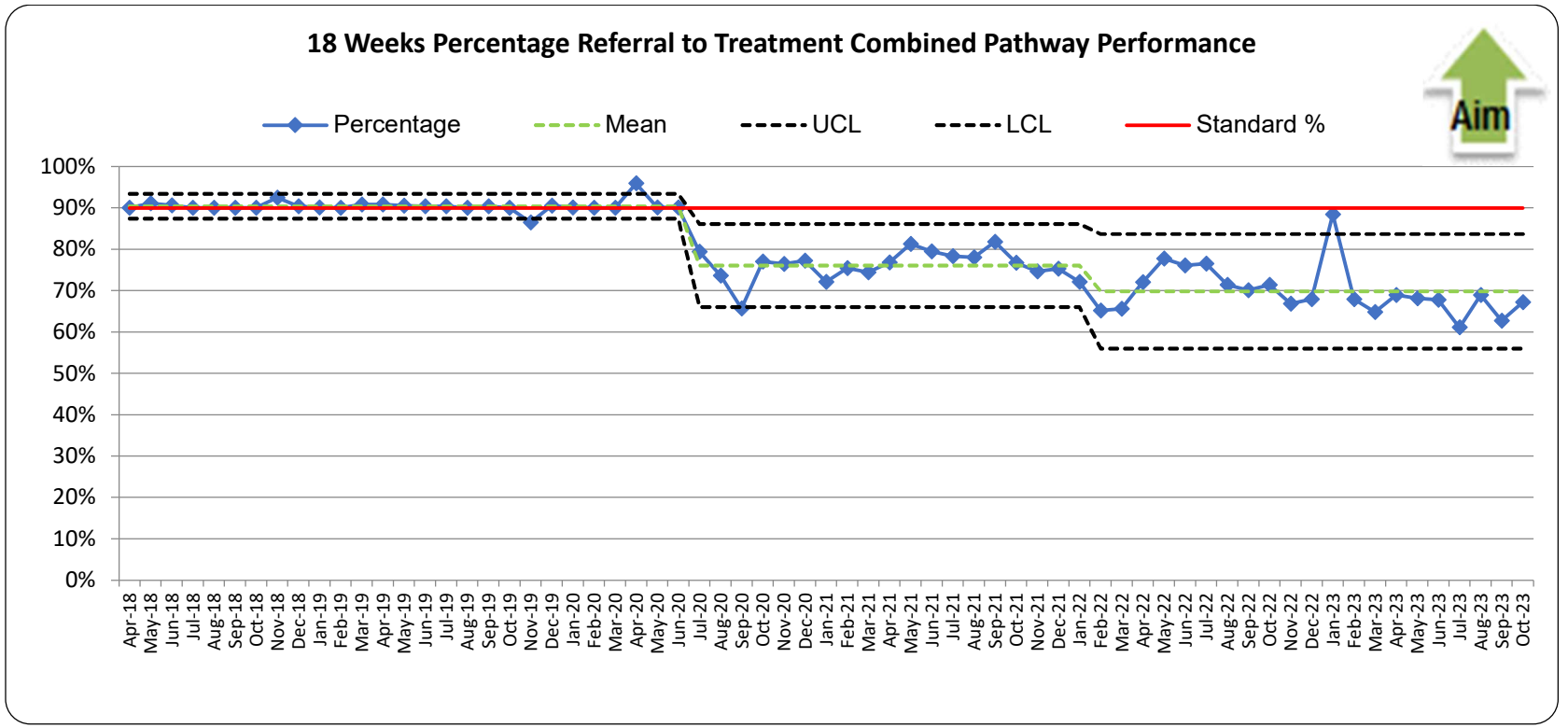


Fig. 15

Diagnostic Waits

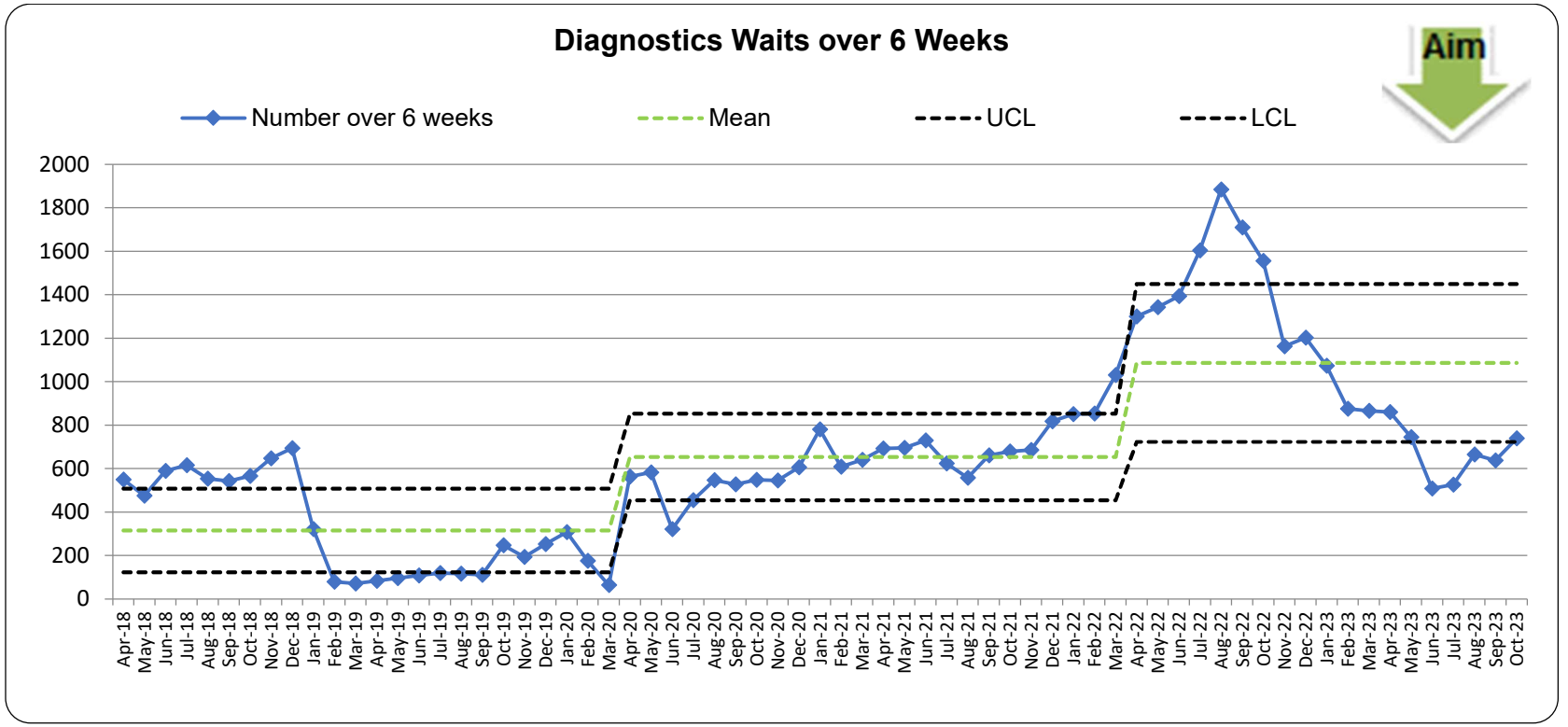


Fig. 16

CAMHS Waiting Times- 18 Week Referral to Treatment *(March-22 data not available at time of reporting due to an issue extracting data from EMIS)*

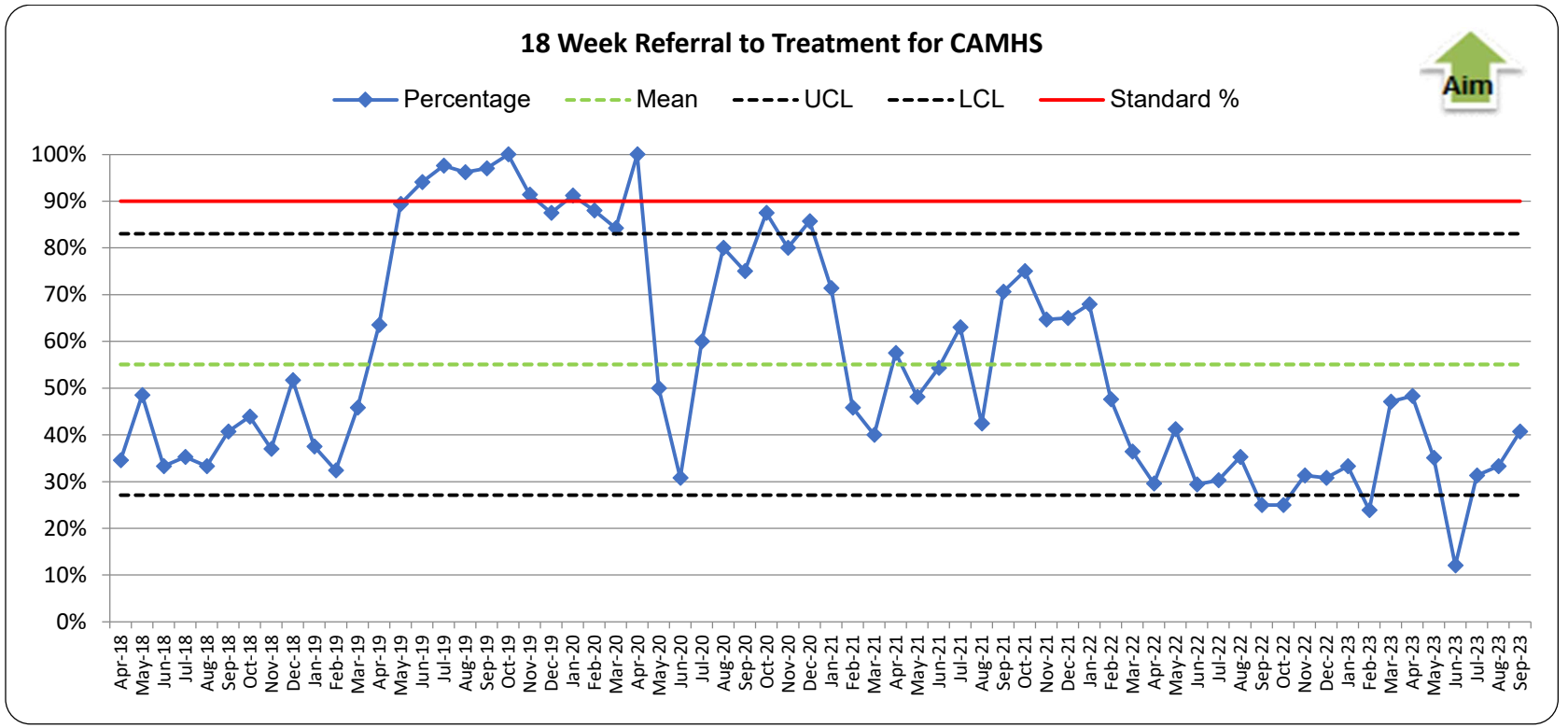


Fig. 17

Psychological Therapies Waiting Times- 18 Week Referral to Treatment *(Please note: From Sep 2019 data includes all PT Services. Renew, the Primary Care PT Service started in October 2020)*

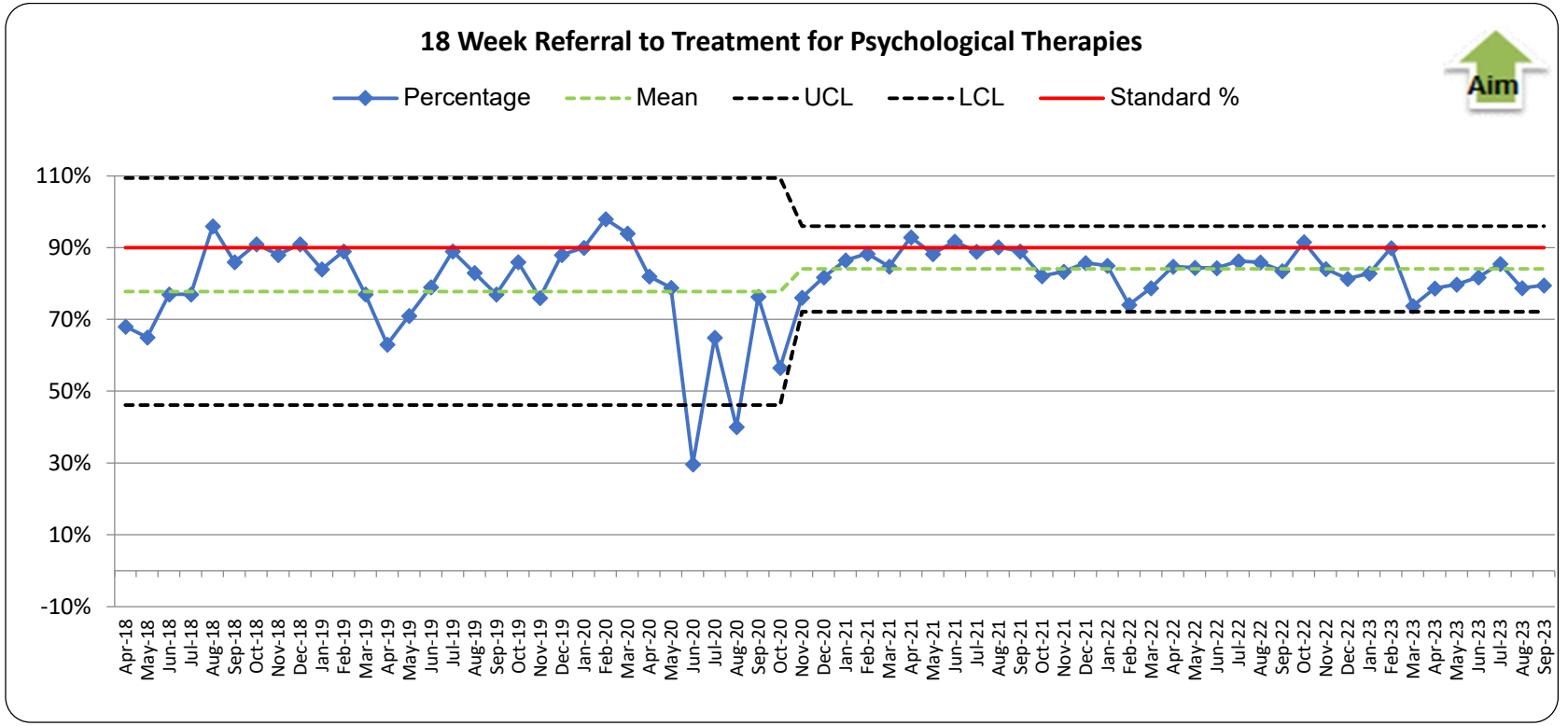


Fig. 18

Delayed Discharges *(Please Note: The census date changed nationally in July 2016 from 15th of every month to the last Thursday of every month)*

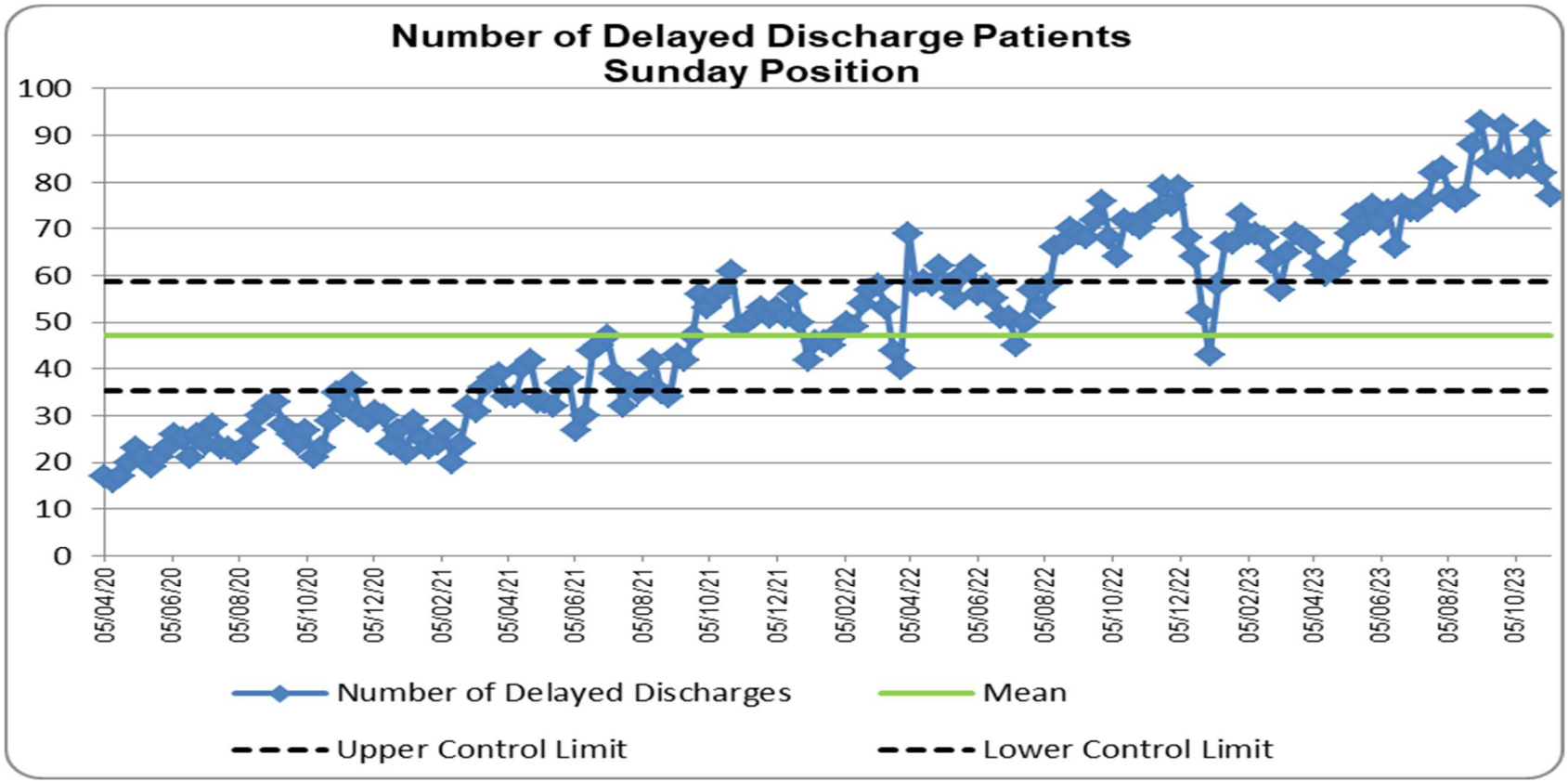


Fig. 19

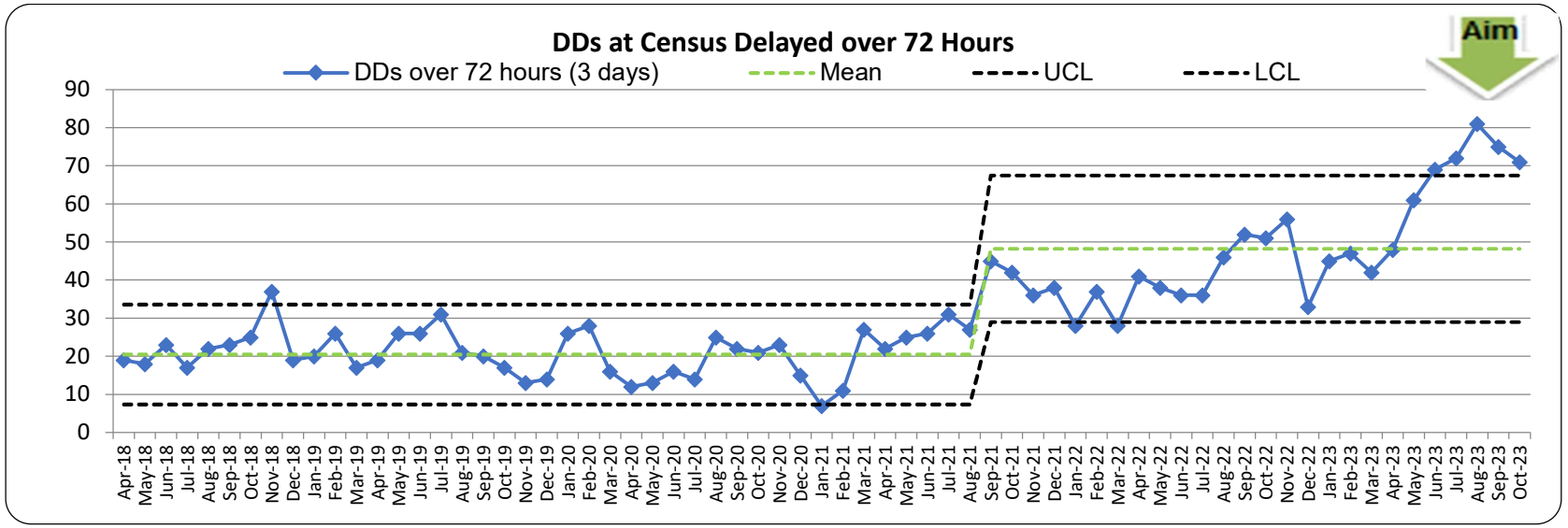

DDs at Census Delayed over 72 Hours
DDs over 72 hours (3 days)
Mean
UCL
LCL
Aim
90
80
70
60
50
40
30
20
10
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23

Fig. 20

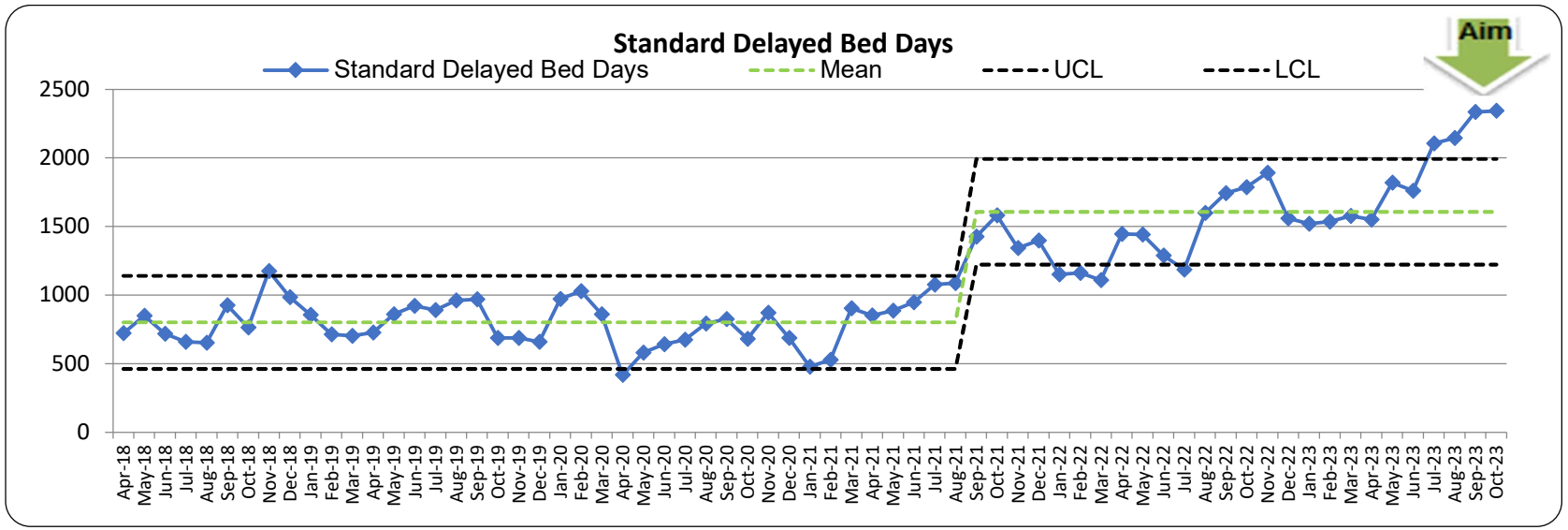

Standard Delayed Bed Days
Standard Delayed Bed Days
Mean
UCL
LCL
Aim
2500
2000
1500
1000
500
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23

Fig. 21

Drugs & Alcohol *(Please Note: Updates provided Quarterly)*

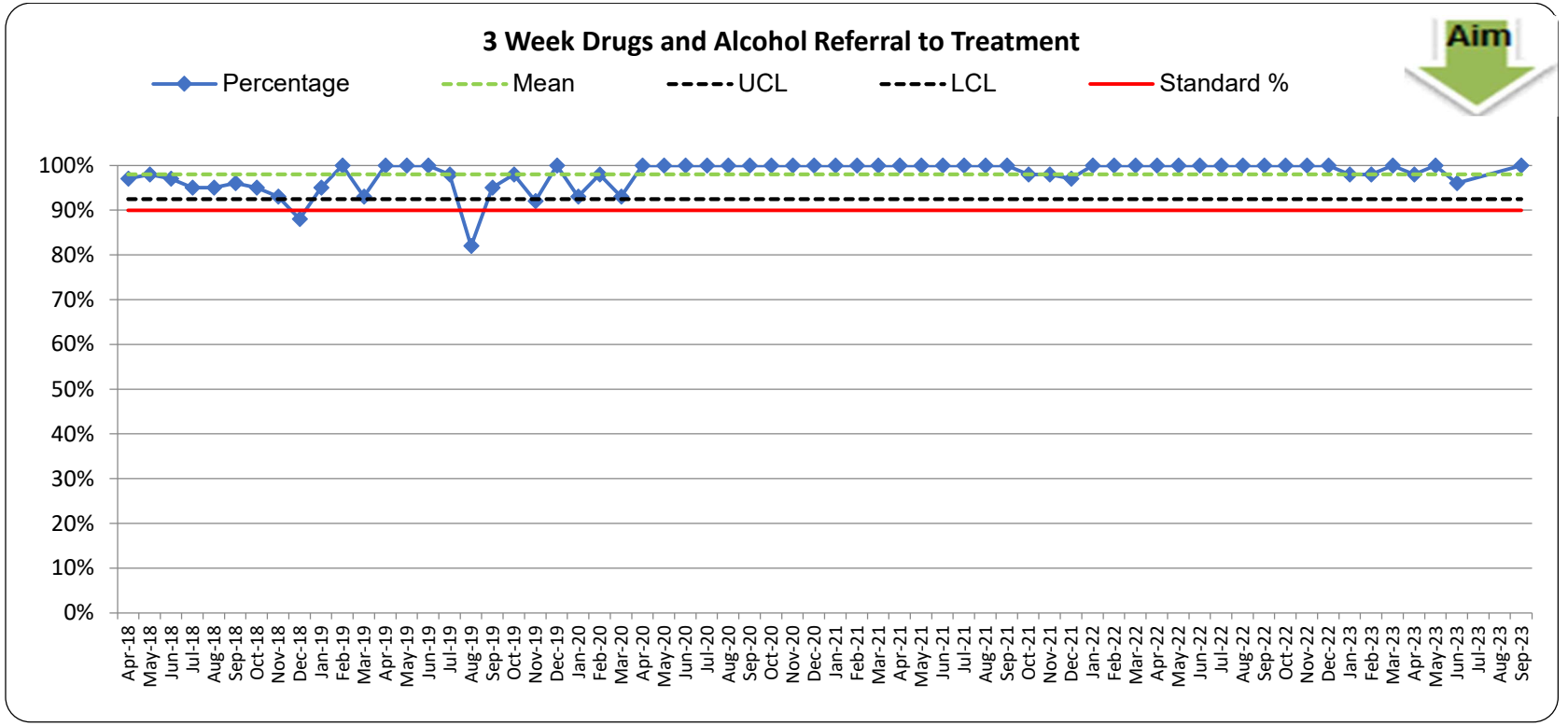


Fig. 22

(Please Note: Standard is 1312 by end of March every year, it then resets back to 0 every April and cumulative reporting starts again. There is a reporting lag in some areas which means that data is not fully reconciled at time of reporting therefore should be treated as provisional.)

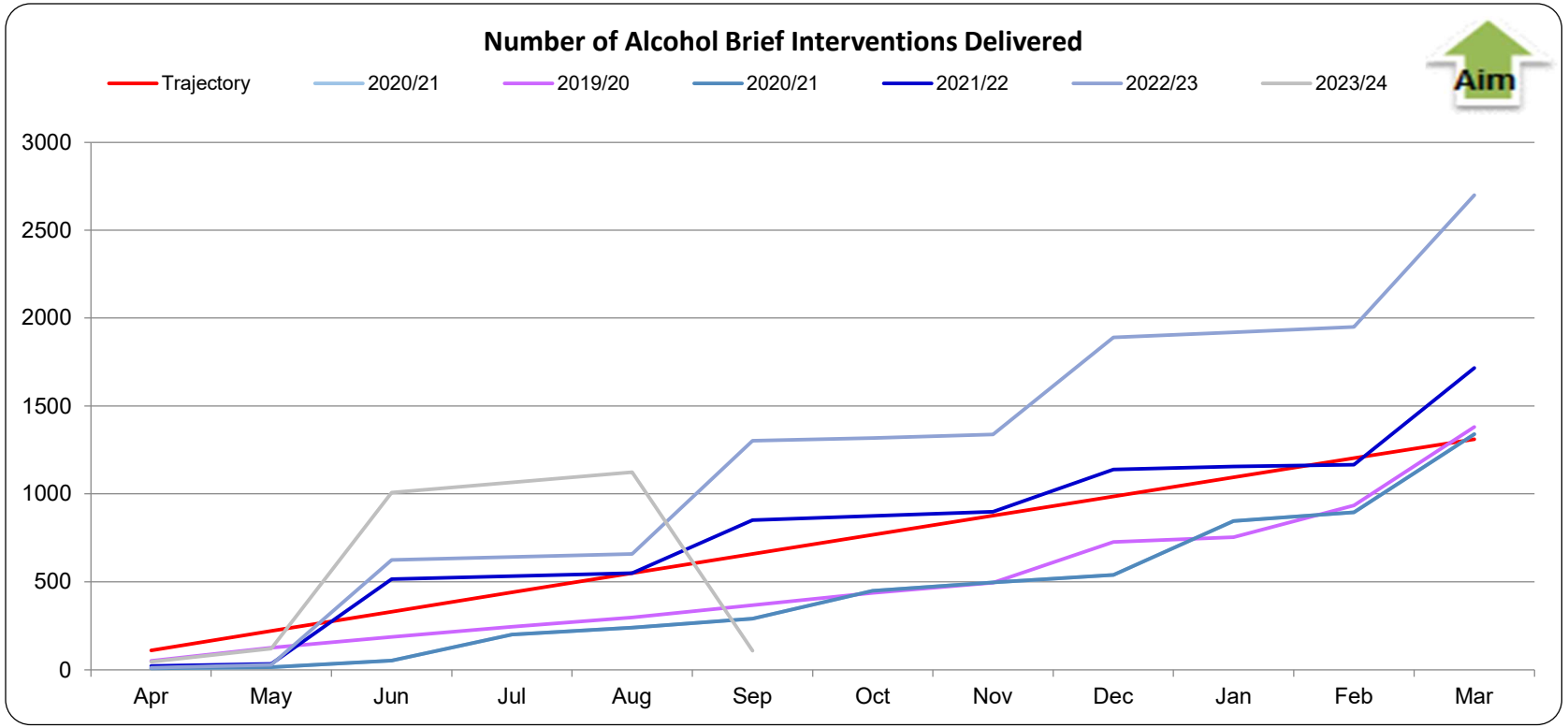


Fig. 23

Sickness Absence

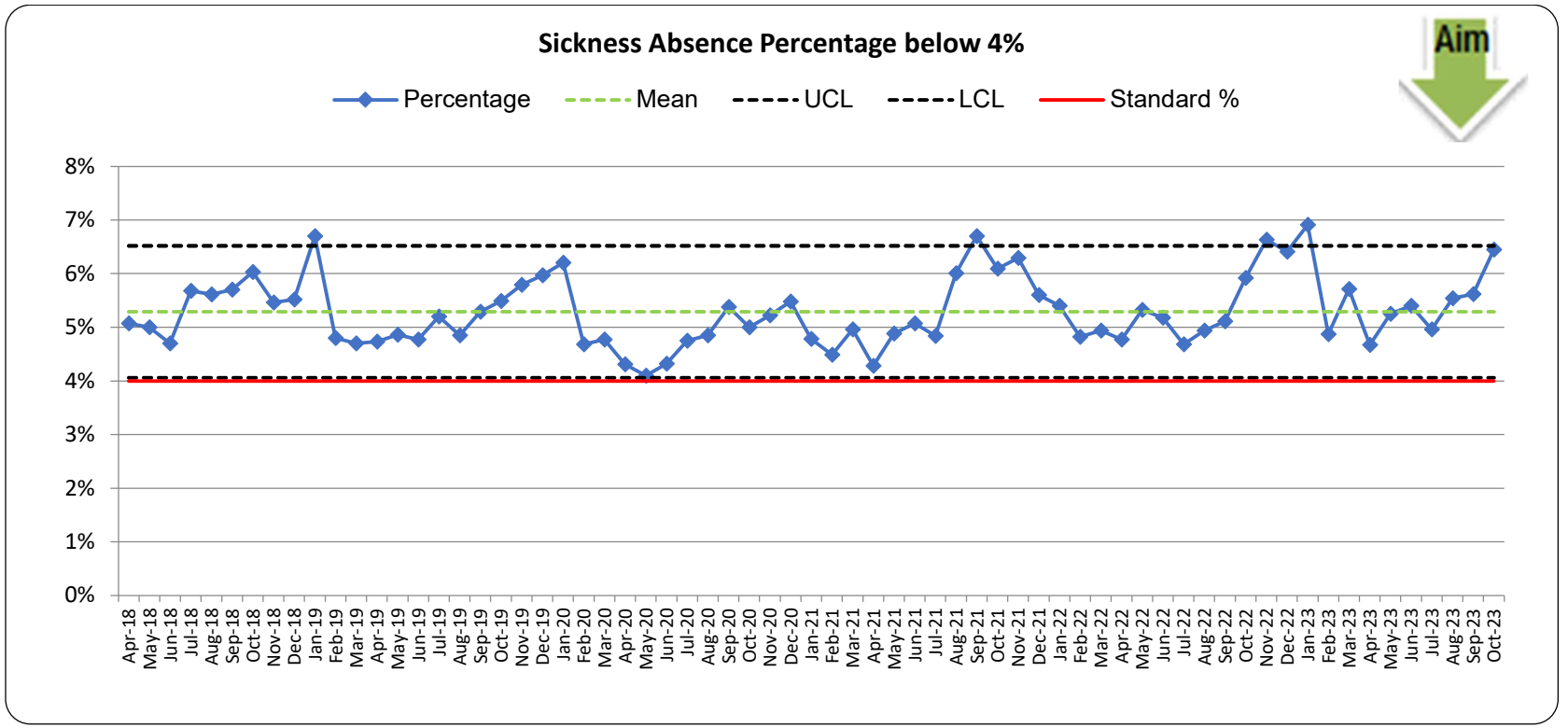
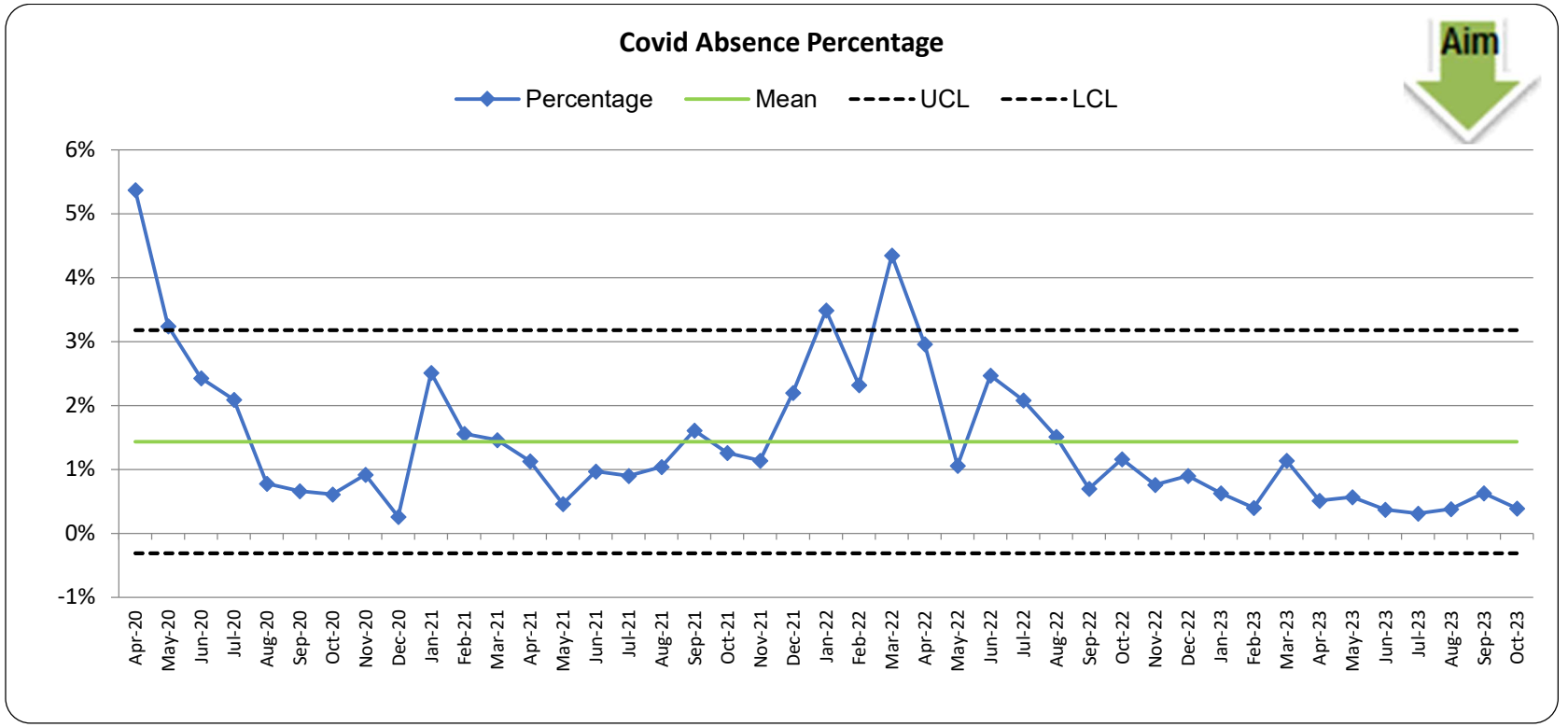


Fig. 24


Covid Absence Percentage
Aim
Percentage
Mean
UCL
LCL
6%
5%
4%
3%
2%
1%
0%
-1%
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
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Jan-23
Feb-23
Mar-23
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Sep-23
Oct-23

Fig. 25

Smoking Quits *(Please Note: All figures are cumulative. Data is reported quarterly to allow monitoring of the 12-week quit period. There is a 6-month lag time for reporting to allow monitoring of the 12 week quit period)*

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
97.2% (2019/20)	77.4% (2019/20)

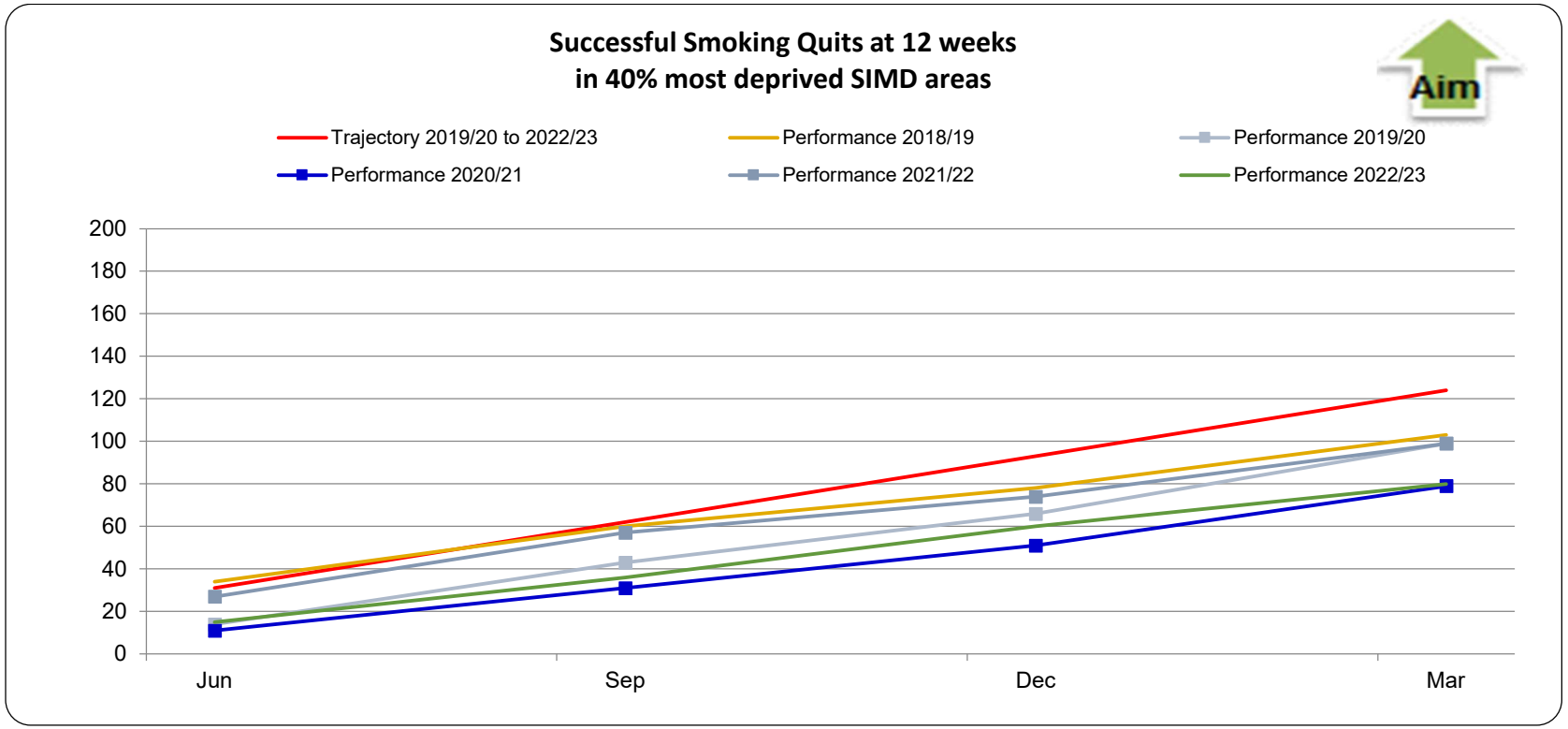

Fig. 26

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Consultant Appointments**
Responsible Executive/Non-Executive:	**Andy Carter, Director of HR & OH&S**
Report Author:	**Bob Salmond, Associate Director of Workforce**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to notify the Board of recent consultant appointments offered by the Chair or their deputy on behalf of NHS Borders Board.

2.2 Background

Board members were briefed in December 2017 on revisions to the NHS Borders guidance on medical consultant appointments. As a result, the Chair of the Board or his/her deputy have delegated authority to offer consultant appointments on behalf of the Board.

2.3 Assessment

Since the last report to the Board, 1 new consultant has been interviewed, offered and accepted a consultant post.

New Consultant	Post	Start Date
Dr Shireen Irfan Ahmed	Consultant Obstetrician & Gynaecologist	March 2024

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to note the report.

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

3 List of appendices

Not applicable.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 December 2023**
Title:	**Integration Joint Board Minutes**
Responsible Executive/Non-Executive:	**Chris Myers, Chief Officer Health & Social Care**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Integration Joint Board with the Board.

2.2 Background

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Integration Joint Board 15 November 2023

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Integration Joint Board minutes 20.09.23

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 20 September 2023** at **10am** in the Council Chamber, Scottish Borders Council and via Microsoft Teams

Present:

(v) Cllr T Weatherston (Chair)
(v) Cllr R Tatler
(v) Cllr E Thornton-Nicol
(v) Mrs K Hamilton, Non Executive
(v) Mr T Taylor, Non Executive
(v) Mr J McLaren, Non Executive
Mr C Myers, Chief Officer
Mr N Istephan, Chief Executive Eildon Housing
Mrs J Smith, Borders Care Voice
Ms L Jackson, LGBTQ+
Mr S Easingwood, Chief Social Work Officer
Mr D Bell, Staff Side, SBC
Dr R Mollart, GP
Mrs J Amaral, Borders Community Action

In Attendance:

Miss I Bishop, Board Secretary
Mrs L White, PA to Chief Officer
Mr P Grieve, Associate Director of Nursing P&CS, NHS Borders
Dr S Bhatti, Director of Public Health
Mrs L Jones, Director of Quality & Improvement, NHS Borders.
Ms J Holland, Director of Strategic Commissioning & Partnerships, SBC
Mrs C Wilson, General Manager Primary & Community Services
Mrs F Doig, Head of Health Improvement
Mrs S Elliot, ADP Co-ordinator
Mr S Burt, General Manager, MH&LD
Ms S Henderson, Planning & Development Officer, LDS
Mr P McMenamin, Deputy Director of Finance, NHS Borders
Ms C Oliver, Head of Communications & Engagement, NHS Borders
Mr D Knox, BBC
Mr A McGilvray, Roving Reporter

1. APOLOGIES AND ANNOUNCEMENTS

1.1 As the Chair had submitted their apologies and the Vice Chair, Cllr David Parker would be late in attending the meeting, the voting membership nominated Mrs Karen Hamilton to Chair the meeting until Cllr Parker arrived.

1.2 Apologies had been received from Mrs L O'Leary, Non Executive, Cllr D Parker, Elected Member, Cllr N Richards, Elected Member, Mrs F Sandford, Non Executive, Mrs H Roberts, Chief Financial officer, Mrs L Gallacher, Borders Carers Centre, Dr L McCallum, Medical Director, Mrs S Horan, Director of Nursing, Midwifery & AHPs, Mr A Bone, Director of Finance, NHS Borders, Mrs J Stacey, Chief Internal Auditor, Mr R Roberts,

Chief Executive, NHS Borders, Mr D Robertson, Chief Executive, SBC, Mrs J Smyth, Director of Planning & Performance, NHS Borders.

1.3 The Chair welcomed attendees and members of the public to the meeting including Mrs C Wilson, General Manager Primary & Community Services, Mr S Burt, General Manager MH&LD, Mrs F Doig, Head of Health Improvement and Mr P McMenamin, Deputy Director of Finance

1.4 The Chair noted that it was the last meeting that Mr Stuart Easingwood would attend as he moved on in his career. The Chair invited the Board to record their thanks to Mr Easingwood for his expertise and advice over the past years.

1.5 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were no declarations made.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 19 July 2023 were approved.

4. MATTERS ARISING

4.1 There were no matters arising.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were no live actions on the action tracker and no matters arose from the minutes of the previous meeting.

5. DIRECTION: HOSPITAL AT HOME

5.1 Mrs Cathy Wilson provided an overview of the report and advised that the test of change would be extended in order to explore a further evolved model recognising the unique challenges of the Borders. She further provided a range of reasons for the expansion to go ahead such as: addressing inequalities in the final business case through expanding the service to Hawick; increased complexity of patients; increased referrals to Hospital at Home; demand is exceeding capacity; mixing teams and including a junior doctor, advanced nurse practitioner, pharmacist and dietician; testing over medication to avoid sedation; test the model over the winter period; maintenance of packages of care; District Nursing teams skill mix; moving from a 5 day to a 7 day service; and comparable data for discharge rates from the service compared to wards in the acute hospital.

5.2 Discussion focused on: staffing challenges; training; assurance that the IA commitments would be achieved; Programme Board to help educate and support the team in regards

to the duty under the Fairer Scotland Act; extending the package of support to include physical adaptations to peoples home to ensure the medical care has the best change to be as effective as possible; inclusion of the Carers Centre to assist with the evaluation of the wellness of carers going forward; social disadvantage as we move into winter and links available to money wise, third party organisations and adult protection; clinical nurse specialists may be of more value in the community than the secondary care setting; would be useful to see data on patients that cannot be accepted; psychological safety is a test of change; national portal and mentors for support; alternative staffing roles such as Assistant Nurse Practitioners and physician assistants to maximise the model; and lots of interest in the service at a national level.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted progress made between April 2023 until August 2023;

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** extended the current TOC, scheduled to end 27 October 2023, to run until 31 March 2024; and

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted HaH team's intention to apply for further funding by September 2023.

6. COMMUNICATIONS AND ENGAGEMENT FRAMEWORK

6.1 Mrs Clare Oliver provided an overview of the content of the paper and highlighted setting out the approach to delivery of the strategic framework and referenced the involving people framework which was considered evidence of a mainstreaming action.

6.2 Discussion focused on: measuring engagement activity and behaviour change as a helpful extension to the Stage 3 IA process; staff training and awareness; challenges of engaging with the public; focus on older people engagement, where is the younger people engagement; good baseline; evolving framework; reach into individual community councils; and engaging with children and young people does occur.

6.3 Mr Chris Myers advised that whilst Mrs Jill Stacey had sent her apologies she wished the Board to note that "the approval of the Framework would demonstrate the implementation of an agreed improvement and therefore enable a 2021/22 Internal Audit recommendation for the IJB (AUDIT.175) to be marked as completed."

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the HSCP Communications and Engagement Framework 2023-2026.

7. FINANCIAL OUTLOOK UPDATE

7.1 Mr Paul McMenamin provided a short presentation on the Quarter 1 financial position. He highlighted several elements including: outturn variance of £8.2m; pressure in social care functions in non delegated functions primarily; LD service pressures and funding tranches have been drawn down; underspends in home care and reduction in the use of agency staff; delegated health care functions have significant pressure in regard to efficiency savings; prescribing pressures; undelivered savings positions; set aside healthcare functions and mitigating actions; and a communication just received from the

Scottish Government to Health Boards and the Partnerships to identify where they hold reserves that were based on funding allocations made this year or previously with a view to relaxing the ring fencing to enable them to be used more creatively to help the bottom line position.

7.2 Discussion focused on: over spending on the over medicalisation of the entire health and care system through the prescribing budget; upstream investment in prevention; balance of helping people to deliver the best outcomes for people at the lowest cost; opportunities in encouraging health to engage with the social prescribing project; social care are not allowed to overspend on their budget and lots of financial input is provided to them to achieve break even; presentation of the budget to allow to get upstream; strategic oversight and service delivery; allocation of resources to areas for best value; and a key objective to focus on prevention and early intervention as the ADP is developed.

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

8. UNSCHEDULED CARE SURGE PLANNING AND DELAYED DISCHARGE TRAJECTORY UPDATE

8.1 Mr Chris Myers provided an overview of the content of the report and highlighted: high impact actions matched to bed occupancy; aim to close existing surge capacity; and management of risks.

8.2 Mr Tris Taylor welcomed the layout of risks being tabulated and enquired how they impacted each other and if they multiplied. Mr Myers commented that the intention had been to record any actions that would have an impact on the delivery of an improved position and to record the risks of non delivery. He expected to be in a better position when actions were progressed as they would mitigate the relevant risk.

8.3 Mr Taylor commented that the financial risk created clinical risk and heightened other risks, and what was missing was the opportunity to reduce expenditure.

8.4 Mrs Jenny Smith enquired what the alternatives were and welcomed the whole sector approach to try and address the matter. She enquired about commissioning, negotiating and billing. Mr Myers commented that more work had been carried out in with the third sector in terms of commissioning in the winter to look at what the opportunities were.

8.5 Mr Nile Istephan enquired if there was a clear position on RAAC. Mr Myers commented that surveys were being conducted nationally across the health and education sectors and priorities were being identified in accordance with perceived risk. He advised that there was no significant concern in regard to RAAC, however surveys were on-going.

8.6 Cllr Tom Weatherson enquired about the impact of the movement of staff in closer contact with other staff across the hospital setting. Mr Myers advised that he would clarify the point as staff followed infection control procedures when contacting staff in different areas.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress made by the HSCP Joint Executive Team on actions which support surge planning

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the delayed discharge trajectory

9. SCOTTISH BORDERS HSCP LEARNING DISABILITY SERVICE COMING HOME PROGRAMME

9.1 Mr Simon Burt provided a presentation on the Coming Home programme and highlighted several key elements including: strategic direction to ensure people are cared for as close to home as possible; dynamic support register monitoring by Scottish Government; current demand is 12 people in out of areas placements; prediction is 3 people coming through the system per year; Coming Home Programme Board and associated workstreams; financial implications; Scottish Government allocation; and risks and mitigations.

9.2 The Chair commented that some individuals in long term placements may potentially consider their placement as home and not recognise the Scottish Borders as their home. Mrs Susan Henderson commented that there were some 19 people in out of area placements who were happily settled and did consider those facilities as their homes.

9.3 Dr Sohail Bhatti suggested the issue represented capacity rather than risk and suggested the commissioning of a private provider or registered social landlord to base a facility in the Borders could generate extra resource and potentially attract clinicians.

9.4 Mrs Julianna Amaral enquired in terms of specific support required and what the gaps were in the Scottish Borders.

9.5 Cllr Elaine Thornton-Nicol enquired if the anticipated additional placements each year were drawn from the transitions process for 14 year olds, so that a more definitive forecast could be provided instead of an averaging. She was concerned about the appropriateness of on-going input of a 5:1 staffing ratio in private hospitals for individuals, especially if there was no improvement plan or improved outcomes for the individual. She suggested an early involvement with children's services to identify potential future service users be considered.

9.6 Mr Stuart Easingwood commented that he was supportive of the programme and that children's services were in a similar position in the sense that they were seeing a new level of complexity in child cases. He advised that there was also already a good partnership approach with registered social landlords to look at future solutions. In terms of predictors for the future, he agreed that more involvement with children's services was required and he emphasised that people were also identified through adult LD services. He also reminded the Board that there were people that migrated into the Scottish Borders with complex needs.

9.7 Mr Nile Istephan commented that the properties at Kelso that were alluded to earlier in the discussion were Eildon Housing properties and they represented a £600k investment by Eildon (60%) and the Scottish Government had funded the remaining 40%. The

properties were for service users and further work was being taken forward to find solutions for vulnerable people. He suggested there was positive collaboration and partnership opportunities across the housing sector to provide people with complex issues with a home environment and support. There were challenges in terms of workforce to ensure the sustainability of services.

9.8 Mr Burt welcomed the discussion and commented that the service worked closely with children's services and with registered social landlords. He reassured the Board that younger people in the age range 13-14 years old were being identified and services liaised closely with clinical teams who regularly visited clients.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** supported the initiatives being developed to achieve the Scottish Governments strategic aims set out in the "Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs" and 'Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge' (2022**).**

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the Scottish Government would be monitoring the H&SC partnerships progress in achieving the Strategic aims set out in the reports in 2.1a via the "Dynamic Support Register".

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that based upon current forecasts, to deliver placements for all 17 people in scope created a financial plan gap.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed with the development of a future funding model between NHS Borders, Scottish Borders Council and the IJB, which will require resources to be identified within the totality of the IJBs financial plan.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** remitted the Chief Officer to escalate the funding risk to the Scottish Government on behalf of the Integration Joint Board and the Health and Social Care Partnership, and to seek a national risk share approach to better support the financial risk for areas with relatively smaller populations.

10. PRIMARY CARE IMPROVEMENT PLAN ANNUAL PROGRAMME REPORT

10.1 Mrs Cathy Wilson provided an overview of the content of the report and highlighted that it was a look back from April 2022 to March 2023 and she highlighted that the report showcased the good work that had been achieved during that period.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the content of the report and considered the issues raised in the report.

11. ALCOHOL AND DRUGS PARTNERSHIP ANNUAL SURVEY RETURN TO SCOTTISH GOVERNMENT 2022-23

11.1 Mrs Fiona Doig provided an overview of the content of the report.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved final sign off of the Annual Survey.

Cllr Robin Tatler left the meeting.

The meeting was no longer quorate.

12. DIRECTIONS TRACKER

12.1 Mr Chris Myers provided an overview of the content of the directions tracker.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Directions Tracker.

13. STRATEGIC PLANNING GROUP MINUTES: 07.06.23, 05.07.23

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

14. ANY OTHER BUSINESS

14.1 Mr Chris Myers provided an outline of the format for the IJB Development session to be held on Wednesday 18 October. He advised that it would include a discussion on the roles and remit of the IJB and a visit to the Community Equipment Store in Tweedbank.

14.2 Mr Myers also advised that the Chief Social Work Officer Annual Report would be submitted to the November IJB meeting for noting.

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

15. DATE AND TIME OF NEXT MEETING

15.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 15 November 2023, from 10am to 12 noon through MS Teams and in person in the Council Chamber, Scottish Borders Council.

15.2 Cllr Tom Weatherston recorded the thanks of the IJB to Mrs Karen Hamilton for stepping in and chairing the meeting at the last minute.