Borders NHS Board

A meeting of the Borders NHS Board **will be held on** Thursday, 1 August 2024 **at 9.30am** in the **Council Chamber, Scottish Borders Council and via MS Teams**

AGENDA

Time	No		Lead	Paper
9.30	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
9.31	**2**	**DECLARATIONS OF INTEREST**	Chair	*Verbal*
9.32	**3**	**MINUTES OF PREVIOUS MEETING** 27.06.24	Chair	*Attached*
9.33	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
9.35	**5**	**STRATEGY**		
	5.1	Items of Low Clinical Value	Director of Pharmacy	Appendix-2024-54
	5.2	ED Workforce Review	Director of Acute Services	Appendix-2024-55
10.30	**6**	**FINANCE AND RISK ASSURANCE**		
	6.1	Finance Report	Director of Finance	Presentation
	6.2	Energy Efficiency Grant Contract	Director of Finance	Appendix-2024-56
	6.3	NHS Borders Private Patients Funds Annual Accounts	Director of Finance	Appendix-2024-57
11.30	**7**	**ITEMS TO NOTE**		
	7.1	Clinical Governance Committee minutes: 29.05.24	Board Secretary	Appendix-2024-58
	7.2	Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2024-59
	7.3	Q4 Risk Report 23/24	Director of Quality & Improvement	Appendix-2024-60

	7.4	Medical Education Report: April 2023-March 2024	Medical Director	Appendix-2024-61
	7.5	Quality & Sustainability of Acute Services	Director of Acute Services	Appendix-2024-62
	7.6	Performance Scorecard	Director of Planning & Performance	Appendix-2024-63
11.59	**8.**	**ANY OTHER BUSINESS**		
12.00	**9.**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 3 October 2024 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams	Chair	*Verbal*

Borders NHS Board

Minutes of a meeting of **Borders NHS Board** held on Thursday 27 June 2024 at 9.30am in the Lecture Theatre, Headquarters/Education Centre and via MS Teams.

Present:
Mrs K Hamilton, Chair
Ms L Livesey, Non Executive
Mrs H Campbell, Non Executive
Mr J Ayling, Non Executive
Cllr D Parker, Non Executive
Dr K Buchan, 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
Mrs J Smyth, Director of Planning & Performance
Mr C Myers, Chief Officer, Health & Social Care
Mr A Carter, Director of HR, OD & OH&S
Mrs L Jones, Director of Quality & Improvement
Mrs M O'Reilly, Head of CP&D
Mrs C Lyall, Planning & Performance Manager
Mr S Whiting, Infection Control Manager
Ms F Doig, Head of Health Improvement/ADP Strategic Lead
Mr J Boyd, Audit Scotland
Mrs C Oliver, Head of Communications & Engagement
Mr A McGilvray, Senior Reporter
Mr D Fergusson, BBC
Mr G Forbes, Office for Mrs R Hamilton MSP

1. Apologies and Announcements

1.1 Apologies had been received from Mrs F Sandford, Non Executive, Mrs L O'Leary, Non Executive, Mrs S Horan, Director of Nursing, Midwifery & AHPs, Mr J McLaren, Non Executive and Mrs L Huckerby, Interim Director of Acute Services.

1.2 The Chair welcomed Mrs M O'Reilly to the meeting who was deputising for Mrs S Horan.

1.3 The Chair welcomed a range of attendees to the meeting including members of the public and press.

1.4 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 no declarations.

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting of Borders NHS Board held on 4 April 2024 were approved.

4. Matters Arising

4.1 Mrs June Smyth provided an update on Time for Change and commented that when the summary report had been presented to the Board in February 2024 section 2.4 of the report on 'Next Steps' said that: *"Considering the changing financial position, we will now review the output of Time for Change and how we should progress with the planned next phases of engagement. A further update and recommendation on next steps will be provided to the next Board meeting."*

4.2 Mrs Smyth advised that the outline vision for Phase 2 was that it would be designed around the transformation bundles and resulting potential for change that were being worked on by the business units; and there was a strong likelihood that it would focus on specific areas within those bundles, accompanied by a strategic overarching narrative about progress against savings delivery and financial recovery plan. In addition there was an intention to develop a social movement around population health and wellbeing, led by Public Health colleagues.

4.3 Mrs Smyth commented that they were not yet in a position to identify and agree those areas of focus; and therefore detail of Phase 2 was not in place at the current time. Plans had also been impacted by the timing of the general election which would impact on public engagement activity; and also the Scottish Governments plans for *"reforming services and reforming the way we work"* as per the letter to Chairs and Chief Executives from Caroline Lamb dated 5 June 2024 - the detail of which was yet to be worked through.

4.4 Mrs Smyth remained committed to involving the public, in line with Planning with People guidance and the Involving People Framework as well as continuing to explore avenues to ensure that engagement was on a 'once for Borders' basis across the HSCP and the wider Community Planning Partnership wherever possible.

The **BOARD** noted the Action Tracker.

5. 2024/25 Annual Delivery Plan

5.1 Mrs Carly Lyall highlighted that the Annual Delivery Plan 2024/25 had been resubmitted to the Scottish Government on 14 March and a response had been received that advised the plan broadly met the requirements. She assured the Board that no further updates to the plan had been requested and it had now been shared with all services. Work was underway on the key indicators to enable the monitoring of progress against the plan.

The **BOARD** noted the report.

The **BOARD** confirmed it had received significant assurance from the report.

6. Borders Child Poverty Report

6.1 Mrs Fiona Doig provided a brief overview of the content of the report.

6.2 The Chair commented that there was helpful learning to be gleaned from the report with the updated data moving forward.

6.3 Mr James Ayling sought confirmation that with the removal of the Public Governance Committee, that health inequalities in relation to child poverty was not lost sight of. The Chair commented that there were a few elements in regard to scrutiny by the Public Governance Committee that she was keen the Board did not lose sight of and that was why it remained a current feature of the Board Action Tracker.

6.4 Dr Sohail Bhatti commented that he was also making sure it was overseen as part of the wider overseen health inequalities.

6.5 Dr Lynn McCallum enquired how it was moved from a strategy into operational delivery given there were specific areas of deprivation in the Borders.

6.6 Dr Kevin Buchan commented that from a GP perspective poverty could not be prioritised and the effect of that was that there were increasing levels of poverty in some areas. As a Health Board it was required to provide the care to those that needed it and by definition if people were poor they were more likely to need extra health care. The poorer areas did not receive any more or less than other areas and he was keen to see more services put into the areas they were really needed.

6.7 Dr Bhatti commented that he had met with Health Visitors and was keen to turn the strategy into a practice difference given Health Visitors had suggested they were a catch all safety net service.

6.8 Mr Chris Myers suggested the strategy be operationalised through the locality working groups and he would work up plans with Dr Bhatti on how to embed it into the locality approach.

6.9 Mr James Ayling enquired how the Board was progressing as an anchor institution.

6.10 Dr Bhatti commented that it had not been bottomed out what an anchor institution was and what that meant in practical terms. However work was underway to map the services provided in terms of prevention.

6.11 Dr McCallum commented that the Board should acknowledge that it was also about education and housing and was much broader than just health.

The **BOARD** noted the report.

The **BOARD** confirmed it had received significant assurance from the report.

7. Resources & Performance Committee minutes: 07.03.24

The **BOARD** noted the minutes.

8. Audit & Risk Committee minutes: 25.03.24

The **BOARD** noted the minutes.

9. Endowment Fund Board of Trustees: 06.05.24

The **BOARD** noted the minutes.

10. Annual Report & Accounts 2023/24 - *(Restricted to Board members only)*

10.1 Mr Andrew Bone commented that the Annual Report & Accounts version presented to the Board were reviewed by the Audit & Risk Committee on 20 June and at that stage they were still draft. A few minor amendments had been made and the Audit & Risk Committee had met immediately before the Board meeting to agree the final pack for sign off by the Board.

10.2 Mr Bone provided an update on the amendments that had been made which included: presentation of the IJB accounts within the consolidated Board position; pension information; Hutton report; trade union information; and an adjustment around an accrual.

10.3 Mr James Ayling, Chair, Audit & Risk Committee confirmed that the process for the 2023/24 Annual Accounts had been concluded that morning when the Committee had reviewed the accounts in light of tracked changes and had received an unmodified external audit opinion. He confirmed that the Audit and Risk Committee were content to recommend the accounts to the Board for approval.

The **BOARD** adopted and approved the NHS Borders 2023/24 Annual Report and Accounts for the financial year ended 31st March 2024 and

The **BOARD** agreed to submit the approved Annual Report and Accounts to Scottish Government.

The **BOARD** confirmed it had received significant assurance from the report.

11. Annual Audit Report 2023/24 from Audit Scotland - *(Restricted to Board members only)*

11.1 Mr John Boyd highlighted the key messages within the report which included: conclusion of the 2023/24 external audit work; confirmation of an unmodified opinion of the accounts; IJB adjustments; achievement of the statutory deadline for the accounts of the end of June; commentary on significant financial challenges faced by the Board; challenges around the sustainability of the current model within the region; and the acceptance by management of a number of recommendations within the report.

11.2 Mr Ralph Roberts as Accountable Officer, thanked Audit Scotland for concluding the annual accounts in June. In terms of the recommendations he reiterated the

awareness of the challenges around sustainability and both endorsed and accepted them in the spirit in which they were given.

11.3 Mr Bone confirmed that the electronic sign off of the financial accounts and the letter of representation in relation to the Boards' assurances around the information provided to the Auditors were now available for conclusion after the meeting.

11.4 The Chair recorded the thanks of the Board to Mr Boyd and the Finance Team for enabling the completion of the annual accounts within the statutory timeline.

The **BOARD** noted the Annual Audit Report for 2023/24 from Audit Scotland.

The **BOARD** confirmed it had received significant assurance from the report.

12. Endowment Fund Annual Report and Accounts 2023/24 - *(Restricted to Board members only)*

12.1 Mr Andrew Bone confirmed that the annual accounts had been approved by the Endowment Fund Board of Trustees at their meeting on 17 June. They were presented to the Board for noting as they formed part of the Health Boards overall consolidated annual accounts.

The **BOARD** noted the report.

The **BOARD** confirmed it had received significant assurance from the report.

13. Audit & Risk Committee Assurance Report - *(Restricted to Board members only)*

13.1 Mr James Ayling commented that the Audit and Risk Committee were required to produce an assurance report for the Board to support the Annual Report and Accounts. He presented the report for the Boards awareness.

13.2 The Chair recorded her thanks and those of the Board to Mr Ayling for the work he had put into pulling the report together.

The **BOARD** noted the Audit & Risk Committee Assurance Report for 2023/24.

The **BOARD** confirmed it had received significant assurance from the report.

14. Finance Report

14.1 Mr Andrew Bone presented the report for the period up to the end of May and advised that the format of the report had been revised to enhance the information presented and would be further amended throughout the year. He then drew the attention of the Board to: the outturn pro rata forecast; tables around savings; savings plans that had not yet commenced; full review of the financial plan that will show trends and comparisons to what had been projected; expenditure growth and cost pressures; and the assumptions made around savings and subsequent actions that may be required.

The **BOARD** noted the contents of the report including the following:-

YTD Performance	£4.68m overspend
Outturn Forecast at current run rate	£28.08m overspend
Variance against Plan (at current run rate)	£2.32m adverse
Actual Savings Delivery (current year effect)	£4.16m (actioned)
Potential Slippage on Forecast Savings (current year effect)	£1.80m
Projected gap to SG brokerage	Best Case £10.96m Worst Case £13.28m

The **BOARD** noted the assumptions made in relation to Scottish Government allocations and other resources.

The **BOARD** confirmed it had received moderate assurance from the report.

15. Audit & Risk Committee Chair Update Report on Financial Sustainability

15.1 Mr James Ayling provided an overview of the content of the report. He highlighted that financial improvements did not yet meet the financial deficit and the need for stronger leadership in respect of financial transformation.

15.2 Discussion focused on: strengthening the Financial Improvement Plan process; increasing accountability and escalation; leadership challenges; early work on cultural change; compassionate leadership; demand and capacity; value based healthcare; potential to change the thresholds of what is provided; health inequalities; triangulation of information on finance, performance and clinical delivery; and visibility of leadership.

15.3 Mr Bone commented that whilst there were similarities with both audit reports, the internal audit report had been narrow in scope and focused on financial sustainability, and the external audit report was much broader in scope. It was difficult to make decisions on the context of impact on clinical services and that was the main leadership focus, for all Health Boards across NHS Scotland, and that was why the Scottish Government was progressing with its NHS Reform programme which included elements of culture, transformation, improvement and efficiencies.

15.4 Mr Ayling commented that leadership was about being seen and being seen to lead and enquired if there was a role for the Board in visibility and how that could assist the organisation going forward. He also suggested that the organisation need to know that the Board accepted ownership for the difficult decisions to be taken.

15.5 The Chair commented that the financial briefing sessions had been a good opportunity for both visibility and ownership and further thoughts on that would be required moving forward.

15.6 The Chair commented that she had undertaken a morning shift with the porters and had received positive feedback about being seen and understanding the roles of staff groups and the challenges they faced.

The **BOARD** considered the findings of the report and how it could best assist in implementing the recommendations of the report relevant to its function and responsibilities and in particular how it could strengthen its decision making and leadership on matters relating to the financial deficit.

The **BOARD** confirmed it had received limited assurance from the report.

16. Clinical Governance Committee minutes: 13.03.24

The **BOARD** noted the minutes.

17. Quality & Clinical Governance Report

17.1 Mrs Laura Jones provided an overview of the content of the report and highlighted several key elements including: on-going pressures in Dental and GP practices; turnover levels in AHP services; addiction service; national CAMHS target progress; positive mental health commission visits; participate in an FAI relating to a suicide case; mortality review paper; recruitment and emerging pressures in radiology and dermatology; strain on services with delays and impact on elective care and specialist beds.

17.2 Discussion focused on: the significant pressure in the system leading to risk of delays; lack of access to elective care beds; consultant recruitment in vulnerable services such as dermatology; digital innovations; locum roles; impact of the COVID-19 inquiries on workload; levels of distress amongst clinicians; increased complexity of patients in community hospitals; investment in extra care housing, additional nursing and respite care; delayed discharges had decreased but remain high; and challenges with an older population compared to the rest of Scotland.

The **BOARD** noted the report.

The **BOARD** confirmed it had received limited assurance from the report.

18. Infection Prevention & Control Report

18.1 Mr Sam Whiting provided an overview of the content of the report and drew the attention of the Board to: page 11, section 3 surgical site infection and confirmed that the action plan in relation to reducing the risk of infection following a caesarean section had been reviewed; arthroplasty; and hand hygiene audits.

18.2 Dr Lynn McCallum advised that the compliance of hand hygiene in medical staff was being explored in detail by the Associate Medical Directors to ensure better compliance levels moving forward.

18.3 The Chair commented that the COVID-19 data was no longer collated and enquired if there was any information available on current rates. Mr Whiting assured the Board that there were no outbreaks or closures at present, however when patient numbers increased there was a greater risk of transmission and if an outbreak occurred in one unit then all patients int hat unit were isolated. He advised that whilst numbers fluctuated there was no significant increase in numbers.

18.4 Dr McCallum advised that testing on admission to hospital had now been stopped. She suspected it was more prevalent than was being seen and commented that it was dealt with as a regular health care infection.

18.5 Mrs Michelle O'Reilly thanked Mr Whiting and his team for providing such a thorough report on infection control.

The **BOARD** noted the report.

The **BOARD** confirmed it had received moderate assurance from the report.

19. Staff Governance Committee minutes: 29.11.23

The **BOARD** noted the minutes.

20. Area Clinical Forum Minutes: 23.01.24

The **BOARD** noted the minutes.

21. NHS Borders Performance Scorecard

21.1 Mrs June Smyth provided an overview on the content of the report and highlighted several elements including: inability to secure narrative on a couple of items; with the confirmation of the Annual Delivery Plan, the scorecard would be re-formatted for those new targets and other areas that the Board was expected to report on; and over the following few months the report would be expanded to include items that the Board specifically wished to see.

21.2 Mr Ralph Roberts drew the attention of the Board to the improvement in the Child Adolescent and Mental Health Services (CAMHS) position.

The **BOARD** noted performance as at the end of April 2024.

The **BOARD** confirmed it had received moderate assurance from the report.

22. Scottish Borders Health & Social Care Integration Joint Board minutes: 20.03.24, 17.04.24

The **BOARD** noted the minutes.

23. Whistleblowing Annual Report

23.1 Mrs Lynne Livesey presented the Whistleblowing Annual Report and highlighted several key elements including: changes in responsibility for whistleblowing; the small number of cases reported for the past year; the learning and data contained within the report; improvements moving forward in terms of structures, potential for deep dives to ensure processes are working properly; system for collecting, collating and tracking data; accessibility of the intranet and internet whistleblowing sites; Speak up week; and the improvement plan.

23.2 The Chair welcomed the report and acknowledged the wish to cross check the data within the report prior to submission the Independent Whistleblowing Standards Officer.

23.3 Further discussion included: reference to whistleblowing within the iMatter survey results for NHS Borders and as a comparison across other Boards; Inphase the new Datix system will be introduced and has a module to capture whistleblowing data; system for the early raising of concerns; adverse events system; and whilst

medical appraisals remain confidential, if patient safety concerns are raised they are followed through.

The **BOARD** noted the report.

The **BOARD** confirmed it had received moderate assurance from the report.

24. Any Other Business

The **BOARD** noted there was none.

25. Date and Time of next meeting

25.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 1 August 2024 at 10.00am in the Lecture Theatre, Education Centre, Borders General Hospital and via MS Teams (hybrid).

Borders NHS Board Action Point Tracker

Meeting held on 4 April 2024

Agenda Item: Health Inequalities Strategy

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-1	6	The **BOARD** agreed to place an action on the action tracker that would read "The Board would receive an update on progress, scoping of what was already in place, what worked well and what was being progressed."	**Sohail Bhatti**	**In Progress**

Agenda Item: Future of the Public Governance Committee

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-2	16	The **BOARD** paused the recommendation from the Chair of NHS Borders that the Public Governance Committee be formally disbanded.	**Steph Errington**	**In Progress**

Agenda Item: Future of the Public Governance Committee

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-3	16	The **BOARD** agreed the discharge of remits as set out in Table 1 of the paper and that it should set out how it linked to the health inequalities agenda to ensure all those elements were captured.	**Steph Errington**	**In Progress**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 August 2024**
Title:	**Policy for Low-Value Clinical Medicines**
Responsible Executive/Non-Executive:	**Lynn McCallum, Medical Director**
Report Author:	**Malcolm Clubb, Director of Pharmacy**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

There is a collection of medicinal treatments which are regarded as being of a less benefit or have less evidence than is acceptable in evidence-based practice.
De-prescribing these medicines to ensure rational use of resources is important but can be time consuming and result in an increase in public complaints if not managed sensitively.

We are asking the Board to approve a draft policy on Prescription Items of Low Clinical Value for NHS Borders (Appendix 1).

2.2 Background

NHS England published a Low Clinical Value Medicines document in December 2017. This has evolved over time and is now known as "Items which should not be routinely prescribed in primary care".

In 2024, Scottish Government's Therapeutics branch commissioned a Short Life Working Group (SLWG) to review and publish on Low clinical benefit medicines for Scotland. A consultation on the medicines proposed has been commenced by the Scottish Government. The output of the consultation is expected by Autumn 2024, the Chair of the SLWG has indicated an intent to publish "off the shelf" projects with progress reporting functionality and political acknowledgment for the need to change built in.

Following discussion with the GP subcommittee and in-line with the review of procedures of low-clinical value it has been agreed that a policy of not initiating medicines on the expected list or swapping/ceasing where they are deemed to be clinically suboptimal should be agreed by the NHS Borders Board.

2.3 Assessment

Following feedback from the NHS Borders Executive Team and clinicians across the Board a draft policy has been prepared. Appendix one

The medicines on the list for 2024/25 are broken down into three classes

a) Items that should not be prescribed
b) Items which require review and consideration of deprescribing or replacement with alternative East Region Formulary choice.
c) Items available for purchase that do not routinely require a consultation or prescription

2.3.1 Quality/ Patient Care

Due to the assessment of the medicines being reviewed the implementation of the list is unlikely to dimmish quality and patient care.

Ceasing use of some of the medicines may improve patient care as alternatives are likely to be well known to prescribers and any adverse events identified and managed quickly.

Patients, however, may have confidence in the medicines currently prescribed and may not be accepting of the changes.

This policy will need reviewed considering the publication and implementation of the Scottish Government Short-Life working group report following consultation. The working group may highlight extra areas of control required. It is also expected that the Short-Life Working Group will provide political mandate for clinicians to implement rather than review.

A review will also be required annually where medicines are added to the list proposed for controls.

2.3.2 Workforce

To implement the policy as intended prescribers are requested to:

a) No longer initiate medicines on the relevant lists
b) Consider reviewing the drugs at the point of reauthorisation.

Due to the nature of the switches required the Medicines Utilisation team may only be able to help with identification of patients on the relevant medicines. It is unlikely with their FIP work programme underway they will be able to actively pursue implementation at this time.

2.3.3 Financial

Decreased spend. Some classes of medicine will need to be prescribed with more appropriate options, but all options are lower cost and formulary compliant Some of the medicines are likely to be de-prescribed and not replace as patients may not require an alternative as treatment is not effective for them.

2.3.4 Risk Assessment/Management

We recognise some patients will be unhappy with proposed changes to their prescribing. Having all prescribers including GPs and Pharmacy teams supported to deliver a consistent message will be helpful in breaking down barriers to adoption.

To ensure prescribers are supported to implement this policy, we need the Board to endorse the proposed policy.

2.3.5 Equality and Diversity, including health inequalities

A Health Impact Assessment has been carried out between the Lead Pharmacist Medicines Utilisation and Equality and Human Rights Strategic Lead, Scottish Borders Health and Social Care Partnership.

No impact was identified

2.3.6 Climate Change

We also need to recognise the manufacture and supply of medicines is likely to contribute to climate change.
Reducing medicines use is likely to be favourable from a climate change perspective, therefore. Medicines unless disposed of correctly can be environmental pollutants.

2.3.7 Other impacts

No other impacts have been identified

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.

The proposed policy has been widely consulted across the organisation. The consultation path is indicated in the route to the meeting in 2.3.9

As part of a briefing strategy now we need to consider communications firstly to our staff and all prescribers. It has been recommended that some of this is enabled through the Values Based Health and Care team.

The second briefing will need to be with our elected officials. Whilst NHS Borders Board will need to approve this policy. We also need to consider briefing our local MP and MSPs on the policy.

Patients who are unhappy in the implementation of the policy are likely to write to them as a matter of course.

The Director of Pharmacy will take forward this engagement piece with our communication team once the policy is approved by the NHS Board.

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.

Approval Given

Group/Specialty	received	outcome
Primary Care Prescribing Group	9/5/24	Approved
Area Pharmaceutical Committee	9/5/224	Approved
Dentistry (Lead – Adelle McElrath)	23/4/24	Approved
BUCC/BECS (Gordon Sim)	23/4/24	Approved
Rheumatology (Ruth Richmond)	23/4/24	Approved
Clinical Directors (BGH)	13/5/24	Approved
Dietitians	April ‘24	Approved
Value-based Health & Care Group	16/5/24	Approved
IJB (Chris Meyers – JET?)	14/5/24	Approved
Secondary Care Pharmacists	May ‘24	Approved
Mental Health (Amanda Cotton)	May ’24)	Approved
Chronic Pain	April 24	No reply*
Dermatology	April 24	No reply
GP Sub Group	May 2024	Approved with changes
Area Drug & Therapeutics Committee	July 2024	Approved

2.4 Recommendation

- **Decision** – The NHS Borders Board Approve the recommended Policy

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 Items Which Should Not Be Prescribed In NHS Borders Policy
- Appendix No 2 Annual Spend on Medicines covered by the policy

APPENDIX 1

ITEMS WHICH SHOULD NOT BE PRESCRIBED IN NHS BORDERS

TARGET AUDIENCE	All healthcare professionals who prescribe or make recommendations about prescribing
PATIENT GROUP	All patients

Clinical Guideline Summary

- The guideline lists a range of items (e.g. medicines, supplements, devices) considered to be of low therapeutic value.
- The guideline is applicable to all healthcare professionals who prescribe or make recommendations about prescribing in NHS Borders.
- The guideline is applicable unless East Region Formulary supports initiation by secondary or tertiary care Consultant and evidence of the rationale for prescribing is documented on the patient's file.
- The guideline is split into three tables:
    - Items which should not be prescribed,
    - Items which should be reviewed for consideration of appropriateness and/or prescription of alterative East Region formulary choice.
    - Items available for purchase or should be issued via other supply routes that do not routinely require a GP consultation or prescription.

Introduction

The application of evidence-based medicine enables the NHS to provide optimal patient care by offering treatment that is clinically and cost effective. NHS Borders (NHSB) is committed to reviewing the use of all items (e.g. medicines, supplements and devices) that are considered to be of low therapeutic value with a poor (or no) evidence base. A number of these items have been compiled in this guideline. The content is principally based on three documents developed for use in England and Wales; '*Items which should no longer be routinely prescribed in primary care'* (from NHS England and NHS Improvement)[1] and the '*DROP-List'* (from PrescQIPP) [2], as well as the NHS Lanarkshire document published in Jan 2024; "Items which should not be prescribed." and the published work of the National Short-life Working Group

The guideline is applicable to all healthcare professionals who prescribe, or make recommendations about prescribing, in NHSB. It aims to raise awareness of financial responsibility in prescribing, support Realistic Medicine through shared decision-making, encourage prescription review and ensure items with a poor evidence-base are not prescribed. This improves patient safety and ensures value for the NHS. The guideline does not, however, remove the clinical discretion of the prescriber in discussing and agreeing the most suitable treatment for their patients in accordance with their professional duties.

The items listed are not exhaustive and further items will be considered for inclusion in future updates. Potential unintended consequences of the recommendations are included in Appendix 2.

Medicines optimisation

Application of this guideline aims to achieve the following outcomes in line with The Royal Pharmaceutical Society's good practice guide on medicines optimisation[3].

- Treatments of limited clinical value are not used, and medicines no longer required are stopped.
- Optimal patient outcomes are obtained from choosing a medicine using the best evidence (for example, following NICE guidance, local formularies, etc.) and these outcomes are measured.
- Medicines wastage is reduced.
- The NHS achieves greater value for money invested in medicines.
- Patients are more engaged, understand more about their medicines and can make choices, including choices about prevention and healthy living.
- It has become routine practice to signpost patients to further help with their medicines and to local patient support groups.
- Incidents of avoidable harm from medicines are reduced.

Three tables:

The guideline is split into three tables.

1. **Items which should not be prescribed (see Table 1)**

    - These items have a limited (or no) evidence base and should not be initiated. Current prescribing should be reviewed with a view to stop. Safer and more cost-effective alternatives may be considered in line with the East Region Formulary (ERF) or by signposting to self-care as appropriate.

2. **Items which require review and consideration of deprescribing or replacement with alternative ERF choice (see Table 2)**

    - These items have a limited evidence base and should not be initiated routinely. Current prescribing should be reviewed with a view to ensure it is clinically appropriate or could be switched to alternatives in line with the East Region Formulary (ERF)

3. **Items available for purchase that do not routinely require a consultation or prescription (see Table 3)**

    - These items may have an evidence-base but do not routinely require a GP practice consultation or prescription. This means patients/carers may purchase the relevant products for self-care, many of which are available from shops, supermarkets, or community pharmacies. Other specific items may also be available to purchase from optometrists or dentists.

    - When patients require advice in relation to symptoms they can consult their relevant local healthcare professional, e.g. community pharmacist, optometrist, dentist, etc.
        - Guidance on the Pharmacy First Service is available here: https://www.nhsinform.scot/care-support-and-rights/nhs-services/pharmacy/nhs-pharmacy-first-scotland

Table 1: Items which should not be prescribed

Item	Recommendation	Rationale
Co-Proxamol[1]	Do not initiate. De-prescribe in all patients where possible.	• **Patient Safety**. • Non-formulary • Licensed product withdrawn in 2007 due to safety concerns regarding toxicity and fatal overdose. • All use in the UK is now on an unlicensed basis.
Glucosamine and chondroitin[1,4]	Do not initiate. De-prescribe in all patients where possible.	• **Efficacy** • Non-formulary. • Limited evidence of effectiveness. • NICE 'do not do' recommendation: do not offer glucosamine or chondroitin products for the management of osteoarthritis. • Glucosamine is deemed less suitable for prescribing—the mechanism of action is not understood and there is limited evidence to show it is effective. • Patients/carers may choose to purchase products for self-care or seek advice on symptoms from a community pharmacy.
Herbal preparations and homeopathy[1,2] (e.g. belladonna, ruta, valerian, bryonia, arnica, lachesis, etc.)	Do not initiate. De-prescribe in all patients where possible.	• **Efficacy** • Non-formulary. • Lack of scientific evidence. • Some products are associated with severe adverse effects. • Some products may significantly interact with licensed medicines. • There is a risk that use may delay accurate diagnosis of underlying pathology.
Lutein and antioxidants for eye health (e.g. vitamin A, C, E, and zinc) [1,2]	Do not initiate. De-prescribe in all patients where possible.	• **Efficacy** • Non-formulary. • No evidence of benefit. • Products are food supplements and not licensed medicines. • Patients/carers may choose to purchase products for self-care or seek advice on symptoms from a community pharmacy/optician as appropriate.

Item	Recommendation	Rationale
Minocycline	Do not initiate. Re-prescribe in patients currently prescribed this medicine with an appropriate ERF alternative.	• **Efficacy** • Non-formulary • **A PrescQIPP CIC review found no evidence to support the use of one tetracycline over another in terms of efficacy for the treatment of acne vulgaris, and alternative once daily products are available.** • **Minocycline is not recommended for use in acne as it is associated with an increased risk of adverse effects such as drug-induced lupus, skin pigmentation and hepatitis**
Omega-3 fatty acid compounds and other fish oils[1,2]	Not recommended. De-prescribe in all patients where possible.	• **Efficacy** • Non-formulary. • NICE have reviewed the evidence and advise it is not suitable for prescribing. • **Patients are advised to eat a Mediterranean-style diet (more bread, fruit, vegetables and fish; less meat; and replace butter and cheese with products based on plant oils).**
Benzodiazepines for anxiety related to flying[4]	Not recommended. De-prescribe in all patients where possible.	• **Patient Safety** • The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate. • Common side effects include impaired alertness, ataxia, confusion, dizziness and visual disturbance which could pose a significant risk in the event of an on-board emergency. • Possible paradoxical increase in anxiety, hostility aggression and perceptual disorders. • Risk of benzodiazepine withdrawal syndrome, including insomnia, anxiety, tremor, perspiration, tinnitus, perceptual disturbances.

Table 2: Items which require review and consideration of deprescribing or replacement with alternative ERF choice.

Item	Recommendation	Rationale
Alimemazine[8]	Do not initiate. Review and deprescribe existing patients.	• Specialist Initiation only in ERF • No published literature is available to state that alimemazine is superior to other sedating antihistamines. • Alternative first-generation antihistamines, such as chlorphenamine or promethazine, offer a more cost-effective option.
Aliskeren[1]	Do not initiate. Deprescribe existing patients.	• Non-Formulary • Clinically effective but more cost-effective products are available.
Amiodarone[8] **& Dronedarone**	Do not initiate. Only prescribe if no other treatment or option is available for specified conditions.	• Safety & Efficacy • Specialist Initiation only in ERF. • NICE guidance puts greater emphasis on rate rather than rhythm control and clarifies the place of dronedarone in the treatment pathway. • Amiodarone only for severe cardiac rhythm disorders where other treatments either cannot be used or have failed. • Dronedarone for maintenance of normal heart rhythm in 'persistent' or 'paroxysmal' atrial fibrillation after normal heart rhythm has been restored.
Buprenorphine Patches[8]	Do not initiate. Review & reduce to ERF alternative options.	• **Safety & Efficacy** • Non-formulary. • Non-interchangeable brands, with variation in frequency of application. • Not appropriate for acute pain. • High strength patches only licensed for mod-severe cancer pain and severe pain unresponsive to non-opioid analgesics.

Item	Recommendation	Rationale
Choral Hydrate[8]	Do not initiate. De-prescribe if possible.	• **Safety & Efficacy** • Non-formulary • Indicated for the short-term treatment of severe insomnia which is interfering with normal daily life and where other therapies have failed. • BNF classify as being less suitable for prescribing. • MHRA 2021 safety update restricted use to children and adolescents with a suspected or definite neurodevelopmental disorder where the benefits of short-term use outweigh any potential risk. Treatment should be for the shortest duration possible and should not exceed 2 weeks
Dipipanone[1,8]	Do not initiate. Not recommended. De-prescribe if possible.	• **Safety & Efficacy** • Non-formulary. • BNF classify as being less suitable for prescribing. • No evidence it offers any additional clinical benefit or is superior to any alternatives. • Can be misused
Fentanyl[1] **Immediate Release**	Do not initiate. Deprescribe in patients currently prescribed this medicine.	• **Safety & Efficacy** • Non-Formulary. • clinically effective but more cost-effective products are available. • SMC restrictions apply: restricted for use within NHS Scotland for the management of breakthrough pain in adult patients using opioid therapy for chronic cancer pain, when other short-acting opioids are unsuitable
Doxazosin modified- release [1,2]	Do not initiate. Re-prescribe as **Immediate-release** version in all patients where possible.	• **Efficacy** • Non-formulary. • Modified-release preparations have no additional benefit in efficacy over immediate-release preparations and are more expensive. • The long half-life of immediate-release doxazosin allows for once daily dosing.
Perindopril arginine[1,2]	Do not initiate. Re-prescribe to Perindopril **Erbumine** in all patients where possible.	• **Efficacy** • Non-formulary. • No clinical advantage of the arginine salt versus the generic erbumine salt. • More cost-effective products are available.

Item	Recommendation	Rationale
Lidocaine plasters[1,6]	Not recommended. De-prescribe in all patients where possible.	• Licensed for post-herpetic neuralgia only. Restricted for use in patients who are intolerant of first line systemic therapies for post-herpetic neuralgia or where these therapies have been ineffective. • NICE do not recommend lidocaine plasters for treating neuropathic pain. • Prescribe only in exceptional circumstances in arrangement with a multi-disciplinary team. • Discontinue treatment after 2-4 weeks if no response. If the patient has responded to treatment and pain is completely alleviated, then a plaster-free period should be trialed after 7 days of plaster use. Treatment should be reassessed every four weeks to decide whether the number of plasters required to cover the painful area can be reduced, or if the plaster-free period can be extended.
Liothyronine[8,9]	Do not initiate. Deprescribe in patients currently prescribed this medicine.	• ERF status: Treatment with liothyronine should only be initiated and adjusted under the advice and ongoing supervision of an endocrinologist. When the specialist initiates therapy, they should clarify a plan for monitoring blood tests and reviewing the patient, usually within 3 months of initiation of treatment. Once stable the patient should only require annual blood tests.
Nefopam	Do not initiate. Deprescribe in patients currently prescribed this medicine.	• Non-Formulary • December 2013, a SIGN guideline titled “Management of Chronic Pain” identified insufficient evidence on the use of nefopam for chronic pain relief to support a recommendation. The authors recommended NSAIDs, COX inhibitors, and paracetamol before nefopam for patients with chronic non-malignant pain. • Anti-Cholinergic Burden (ACB) score = 2

Item	Recommendation	Rationale
Oxycodone & Naloxone[1]	Do not initiate. Deprescribe in patients currently prescribed this medicine. .	• Non-Formulary • Clinically effective but more cost-effective products are available.
Paracetamol and tramadol combination product[1,2]	Do not initiate. De-prescribe in all patients where possible.	• NHS Borders has <10 patients in the latest year. • Non-formulary. • No evidence that combination product is more effective or safer than the individual preparations. • Contains sub-therapeutic dose of paracetamol. • Safety concerns with tramadol (harms and misuse) and increased numbers of deaths. • More cost-effective products are available.
Trimipramine[1]	Do not initiate. Deprescribe in patients currently prescribed this medicine.	• Non-Formulary. • Clinically effective but more cost-effective products are available.
VSL#3® and Vivomixx® (probiotics)[2,7]	Do not initiate. De-prescribe in all patients where possible.	• Non-formulary. • The ACBS concluded that the evidence did not sufficiently demonstrate that the products are clinically effective. Both products were removed from the Drug Tariff in 2019. • Probiotics should not be prescribed in primary care due to limited evidence of clinical effectiveness.

Table 3 Items available for purchase that do not routinely require a consultation or prescription.

Item	Recommendation	• Rationale
Bath and shower preparations for dry and pruritic skin conditions[1] (e.g. Hydromol® bath & shower emollient, Dermol® bath/shower emollient, Balneum bath oil, Cetraben bath additive, E45 bath oil, Oilatum bath additive, etc.)	Do not initiate. De-prescribe in all patients where possible.	• **Efficacy & patient safety.** • The BATHE randomised controlled trial showed no evidence of clinical benefit for including emollient bath additives in the standard management of childhood eczema. In the absence of other good quality evidence this was extrapolated to adults until good quality evidence emerges. • **Mitigation**: Soap avoidance and 'leave-on' emollient moisturisers can be used for treating eczema (and as a soap substitute). • There is a risk of falls from slipping on the oil film these products may leave on the skin/bath/shower. • Patients/carers may choose to purchase products for self-care or seek advice on symptoms from a community pharmacy.
Rubefacients, excluding capsaicin[1,2.] (e.g. Deep Heat®, Transvasin®, Balmosa®, Deep Freeze®, etc.)	Do not initiate. De-prescribe in all patients where possible.	• Efficacy • Non-formulary. • Limited evidence. • NICE 'do not do' recommendation: do not offer rubefacients for treating osteoarthritis. • Patients/carers may choose to purchase products for self-care or seek advice on symptoms from a community pharmacy.

Travel Vaccines[1,]	Do not initiate except via Vaccination Team.	• The recommendations do not apply to the following vaccines when administered exclusively for the purposes of travel, if clinically appropriate:
		  ○ Cholera
		  ○ Diphtheria/tetanus/polio
		  ○ Hepatitis A
		  ○ Typhoid
		• Clinically effective but due to the nature of the product, are deemed a low priority for NHS funding.
		• These vaccines are included with GMS regulations as being available for prescription to NHS patients.

Item	Recommendation	• Rationale
Multivitamin & mineral preparations[2,4] (including Forceval®)	Do not initiate. De-prescribe in all patients where possible.	• **Efficacy** • Formulary status – Specialist Initiation • Products are food supplements and not licensed medicines. • Mega-vitamin therapy (use of high doses) with water-soluble vitamins, such as ascorbic acid and pyridoxine, is unscientific and can be harmful. • The use of vitamins as general 'pick-me-ups' is of unproven value and, in the case of preparations containing vitamin A or D, may be harmful if the prescribed dose is exceeded. • Vitamins can be obtained through dietary means. • Patients/carers may choose to purchase products for self-care or seek advice on symptoms from a community pharmacy/optician as appropriate. • Some vitamins may be prescribed to prevent/treat deficiency but not as dietary supplements.

Glossary

ACBS	Advisory Committee on Borderline Substances
NICE	National Institute for Health and Care Excellence
NSAID	Non-steroidal anti-inflammatory drug
POMs	Prescription-only medicines

References

1. NHS England and NHS Improvement. Items which should not routinely be prescribed in primary care: Guidance for CCGs. Version 2, June 2019. https://www.england.nhs.uk/medicines-2/items-which-should-not-be-routinely-prescribed/

2. The PrescQIPP DROP-List 2015 (Drugs to Review for Optimised Prescribing). Bulletin 117, July 2015. https://www.prescqipp.info/our- resources/webkits/drop-list/

3. The Royal Pharmaceutical Society. Medicines Optimisation: Helping patients to make the most of medicines. Good practice guidance for healthcare professionals in England. May 2013 https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/helping-patients-make-the-most-of-their-medicines.pdf.

4. Joint Formulary Committee. British National Formulary (online) London: BMJ and Pharmaceutical Press http://www.medicinescomplete.com [Accessed Aug 2023].

5. NHS UK. Common questions about simeticone. Page last reviewed: 13 October 2022. https://www.nhs.uk/medicines/simeticone/common-questions-about- simeticone/

6. NHS Lanarkshire. Neuropathic Pain Treatment Guidelines. April 2019. https://rightdecisions.scot.nhs.uk/media/1783/neuropathic-pain-treatment.pdf

7. UK Medicines Information (UKMi) Comment on Drug Tariff Statement. Probiotics VSL#3 and Vivomixx have been removed from the Drug Tariff, following review by Advisory Committee on Borderline Substances (ACBS). Nov 2018. UKMi

8. NHS Scotland SLWG Consultation paper.

9. PrescQIPP Patient Information Leaflet: https://www.prescqipp.info/media/1370/patient-information-changes-to-liothyronine-prescribing.docx

10. 316. Travel vaccines 2.0 (prescqipp.info)
https://www.prescqipp.info/media/6386/attachment-4-travel-vaccines-patient-information-20.docx
https://www.prescqipp.info/media/6561/attachment-5-travel-vaccines-educational-slideset-21.pptx

11. items-which-should-not-be-prescribed-in-nhsl-final-january-2024-11.pdf (scot.nhs.uk)

Appendices

Appendix 1: Governance information for Guidance document

Lead Author(s)	NHS Lanarkshire Prescribing Quality & Efficiencies Operational Group, adapted for use in NHS Borders, April 2024
Endorsing Body	Area Drug and Therapeutics Committee
Version Number	1.0
Approval date	
Review Date	
Responsible Person (if different from lead author)	

CONSULTATION AND DISTRIBUTION RECORD	
Contributing Authors	
Consultation Process/Stakeholders	- Primary Care Prescribing Group - GP sub-committee - Area Pharmaceutical Committee - Clinical Director for Dentistry - Clinical Lead BUCC & BECS - Dietetics Professional Lead - Secondary Care Pharmacists Group - Associate Medical Director Mental Health and Learning Disability Services - Secondary Care Clinical Directors Group - VBH&C Steering Group - Board Executive Team - Clinical Director for Ophthalmology Consultants in Chronic Pain Consultant Dermatologist - Integrated Joint Board - Area Drug and Therapeutics Committee
Distribution	NHS Borders Right Decision Service NHS Borders Staff Briefing

CHANGE RECORD			
Date	**Lead Author**	**Change**	**Version**
		e.g. Review, revise and update of policy in line with contemporary professional structures and practice	

Appendix 2: Potential unintended consequences of the recommendations

Adapted from: https://www.england.nhs.uk/medicines-2/items-which-should-not-be- routinely-prescribed/[1]

1. There could initially be increased patient appointments in primary/secondary care, however this would not be expected to be sustained.

2. Alternative treatments may not be clinically identical therefore prescribers should explain the rationale for any proposed changes in treatments and come to a shared decision with their patients, utilising appropriate resources to facilitate choice.

3. Alternative treatments could be prescribed with cost consequences; however, this is an opportunity to review and de-prescribe.

4. Demand for alternative treatments could increase (affecting the supply chain) however this guidance is currently only for local use and will be monitored in line with currently known shortages.

5. There is the potential for patient complaints to rise, however health board support and local public consultation and communication will be provided.

6. There is the perceived risk of different products being available on prescription from different health boards however this guideline does not remove the clinical discretion of the prescriber in deciding what is the safest and most effective treatment for their patients in accordance with their professional duties.

Appendix 2

NHS Borders Annual Spend on Items of Low Clinical Value

Most Recent 12 months (April 2023 to April 2024)

Drug	Spend
Alimemazine	£9,650.33
Amiodarone and Dronedarone	£20,261.60
Buprenorphine Patches	£239.12
Chloral Hydrate	£6,106.25
Dipipanone + Cyclizine	£44.07
Dosulepin	£3,001.53
Doxazosin XL tablets	£3,604.48
Fentanyl Instant Release	£27,030.84
Glucosamine Sulfate + Chondroitin	£274.50
Homeopathy	£48.84
Lidocaine Plasters	£260,749.76
Liothyronine & Liothyronine Sodium	£1462.50
Liquid Paraffin and Emollients	£27,783.65
Lutein And Antioxidants	£79.97
Minocycline	£348.81
Multivitamins And Minerals	£9,146.59
Nefopam	£25,947.53
Omega-3 Fatty Acid Compounds	£62.89
Oxycodone and Naloxone	£30.15
Perindopril arginine	£883.95
Probiotics	£3,178.74
Rubefacients And Poultices	£915.72
Tramadol and Paracetamol	£713.01
Travel Vaccines	£0
Trimipramine	£9,317.36

NHS Borders

Meeting:	**NHS Borders Board**
Meeting date:	**1 August 2024**
Title:	**ED Workforce Review**
Responsible Executive/Non-Executive:	**Lynne Huckerby**
Report Author:	**Bhav Joshi, General Manager, Unscheduled Care** **Janice Cockburn, Deputy Director of Finance, Acute Services**

1 Purpose

An Emergency Department (ED) Workforce Review was commissioned by the Medical Director and Director of Acute Services in the Autumn of 2021. The review concluded in April 2023, and was supported in principle by the NHS Borders Board in December 2023. The review demonstrated a robust case to invest in additional medical and nursing workforce to manage safety issues which are most significant in the out of hours' period. Securing a funding stream was agreed as a key next step. Initial consideration was given to the release of funding through transformation activities, however, on review it became clear that the release of transformation funding would take a significant period. In the meantime, the continued and relentless pressure on our ED workforce has been compounded in recent months with the increased demand for our services. This has further compromised safety across the department.

The purpose of this paper is to:

- Approve the recurring investment set out in the ED Workforce Review

This is presented to the Board for:

- Approval

This report relates to a:

- Operational and strategic risk

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

- Safe
- Effective
- Person Centred

2 Report summary

Situation

2.1 Emergency Department (ED)

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 agreement of a care plan. As per National trends, there are wider system issues impacting performance and quality. Since our internal ED workforce review, high levels of bed occupancy have remained which has impacted length of stay, occupied bed days and delayed discharges. This has significantly increased the time spent waiting for an inpatient (IP) bed in the ED, and has resulted in several instances of overcrowding in the department. Prolonged waits in the ED are known to increase the instances of mortality (and avoidable deaths), patient harm and compromise patient safety. An appropriately skilled workforce is key to address these safety considerations.

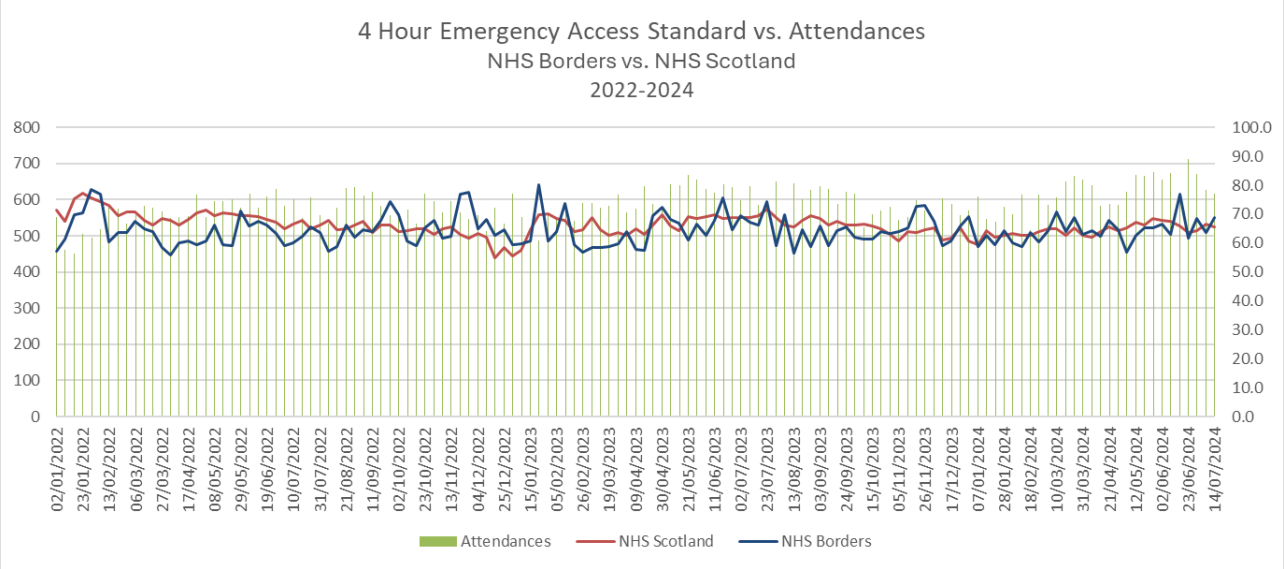


Figure 1 – 4-hour Emergency Access Standard vs Attendances

The three main drivers for change recorded in the ED workforce review (appendix 1) were:

2.1.1 Additional Medical Cover (overnight).

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 across the hospital, and most significantly, this leads to a lack of availability for mutual aid for the single handed senior decision maker in ED.

2.1.2 Skill Mix

A lack of appropriate levels of multi-disciplinary team working across Medical and Nursing professional groups. For Nursing, workforce numbers have not been formally appraised and considered since pre-pandemic (prior to March 2020) and are dated. Currently there is a lack of senior nursing cover in the overnight period which also impacts safety and decision making.

2.1.3 Clinical Risk(s) – derived from above.

This was supported in principle by the NHS Borders Board in December 2023, subject to confirmation of the financial funding route. In May 2024, BET revisited the review following limited route for funding in the short term through transformation avenues.

2.1.4 National Benchmarking

Scottish Government are currently analysing a national benchmarking review on ED staffing profiles which was carried out for week of the 10th June 2024. The result of this exercise is anticipated to be returned by the end of July 2024. It is already known that NHS Borders is an outlier when it comes to the number of senior decision makers in post per 100k population (see Table 1, below). In terms of nursing staffing NHS Borders is currently an outlier in terms of no charge nurse on shift overnight and therefore it is envisaged that recommendations in the workforce review will be in line with the outcome of the benchmarking review.

2.2 The recommendations regarding staffing in the workforce review only considered the core workload and footprint. The surge capacity was not considered to be in scope for recurrent funding.

2.3 The review was supported through a comprehensive governance route which included: Front Door CMT, Acute Quad, Operational Management Group, Borders Executive Team Meeting, Joint Executive Group, Strategic Planning Group, and NHS Borders Board. While the NHS Board supported the recommendations in principle, instruction to proceed was approved based on an agreed Financial Plan. NHS Borders currently does not have a financial plan which is agreed by Scottish Government because the Board is unable to produce a plan that meets the brokerage requirements for 24/25, and provide a balanced plan over a three-year period.

2.4 Throughout the intervening periods between the approval of the review (in principle) and July 2024, NHS Borders has continued to experience a prolonged and persistent period of pressure; this has caused the ED to regularly become

overcrowded with long waits for an IP bed (the longest IP wait during 23/24 was 60 hrs). Moreover, ambulance queues outside of the ED have become routine (known as 'stacked ambulances') and timely handover of patients impacted. This often overspill into the OOH period where the workforce establishment remains insufficient to address basic quality of care and patient safety.

2.5 The ED workforce review makes recommendations based on levels of Nursing and Medical personnel required to address the safety issues concerned with managing the core Emergency Department. Nursing levels were considered against workload tools and professional judgement. The RCEM defines a small or rural EDs as those which typically see less than 60,000 attendances per annum. The ED at BGH typically see between 36,000 and 40,000 attendances per annum and therefore the standards have been reviewed in conjunction with senior nursing management to reflect the size and nature of the ED Department in BGH. This enhancement does little to meet national benchmarking levels, and is at a level below those outlined in the nursing working standards set out in the RCN/RCEM document, October 2020.

2.6 For Senior Medical oversight the RCEM recommends 1 WTE Consultant for between 2600 – 4000 new attendances[1]. The current funded establishment for Emergency Medical (EM) consultants in the BGH is 2.20 WTE.

Table 1 (below) demonstrates current WTE consultant rates vs. National Boards.

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**	**2.2**	**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

[1] RCEM_Consultant_Workforce_Document_Feb_2019.pdf

3.0 Assessment

3.1 A contributing factor to congestion and overcrowding in the ED is the inability to guarantee reliable exit flow from the department. This can be for a variety of reasons and negatively impacts performance. Table 2 (below), shows the gradual deterioration in performance.

	2020	2021	2022	2023	2024
All Unscheduled Care Attendances	504	532	575	589	616
8 Hour Breaches	5	25	90	84	89
12 Hour Breaches	2	11	65	52	57
4 Hour Emergency Access Standard (%)	88.1	77.8	63.9	64.0	63.9
Delayed Discharges	26	39	58	74	77

Median performance against metrics for NHS Borders ED EAS Performance 2020-2023 - published 18 July 2024

Table 2 - Full Year Median Performance 2020 vs 2024

3.3 In order to staff the core ED safely there has been a requirement to use supplementary staffing (including bank/agency) as the workforce review has not been agreed as the recurring establishment. Additionally, throughout 23/24 and into the first quarter of 24/25 an Agency Medical Locum was w in place to ensure there was adequate levels of senior decision making capacity throughout the ED (the model recommended and approved in the ED Workforce Review). This has now subsequently come to an end. The spend within ED for 23/24 excluding the additional funding was £328k overspend on medical staffing and £388k on nursing staff- excluding the impact of the surge funding (Blue ED). Without tolerating this level of overspend there is a high probability that the ED would experience worse pressures than those currently in situ.

3.4 There *are* risks in implementing the recommendations set out in the workforce review. Consultant availability is limited and previous attempts to recruit substantively have failed to lead to appointments. There is also some concern around being able to recruit substantively to the number of other medical staff required to fill the lower grade rota should the additional overnight staffing level be made substantive.

3.5 To bring this piece of work to conclusion despite the financial concerns it is strongly recommended that the review is now approved (in full) in order that a robust implementation plan for the staffing levels agreed in the ED workforce paper can be formulated

1. Funding already identified in the financial plan for appointment of a third consultant for commencement in December 2024/January 2025; Recurring cost £150k

2. Implement nursing enhancement – this will allow recruitment of substantive nursing staff, but would reduce the requirement for use of bank and agency staff in the core ED footprint. But not if Blue ED remain open: Recurring cost £508k

3. Support recurrent funding for the existing temporary arrangements for overnight medical cover while looking to achieve a long term robust solution £494k

3.6 If the above is implemented as per the workforce review recommendation this will require additional funding of £1.152m of which £200k is already funded in the financial plan.

4.0 Workforce

There has been no change to the workforce requirements as set out in the original Workforce review (appendix 1).

5.0 Financial

The implementation of the ED workforce review will require a further £1.2m on a recurring basis of which £0.2m is already within the financial plan. Currently due to the pressure in ED much of the additional staffing is already in place. Should implementation be agreed the in-year impact on NHS Borders overall the financial position will only be in the region of £0.5m. This assumes that workforce model will be fully implemented from around posts Autumn 2024.

6.0 Risk Assessment/Management

There are currently two operational risks on the risk register (4397 – still graded very high) the first risk relating to long waits for beds greater than 4 hours and up to and beyond 40 hours, and due to levels of activity and demand the ED is operating as a medical admission unit. The second risk (1102 – still graded High) relates to the lack of medical expertise in the overnight period.

Additionally, the strategic risk relating to the Quality and Sustainability of our Acute Services incorporates our Emergency Department for the reasons articulated in the review (appendix 1) and subsequently this paper which strengthens the case to address and mitigate the safety risks.

The operational and strategic risks are being managed in accordance with our risk management policies. The approval of this investment will, reduce risk 1102 once full recruitment is achieved and in part, mitigate the remaining risk. The outputs of the national ED benchmarking review are expected to highlight and validate the NHS Borders' ED position and bring an opportunity for further engagement with SG on next steps.

7.0 Communication, involvement, engagement and consultation

The ED staff have been engaged throughout the period of the review as well as been involved as part of the various governance meetings to bring understanding and awareness of the challenges they are exposed to routinely. This level of engagement will continue until conclusion is reached. Full details of the engagement strategy and support for the proposal are shown within Appendix 1.

8.0 Recommendation

NHS Borders Board is asked to:

- Approve the additional recurring £1m funding to implement the full ED Workforce Review staffing model
- Note risk 1102 will be mitigated once full staffing plan is in place
- Note there remains two further high risks (operational/strategic) on the risk register; and
- Note the continued requirement for surge capacity across ED will remain until system wide delays resolve. This in turn will continue to negatively impact performance across front door areas.

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).

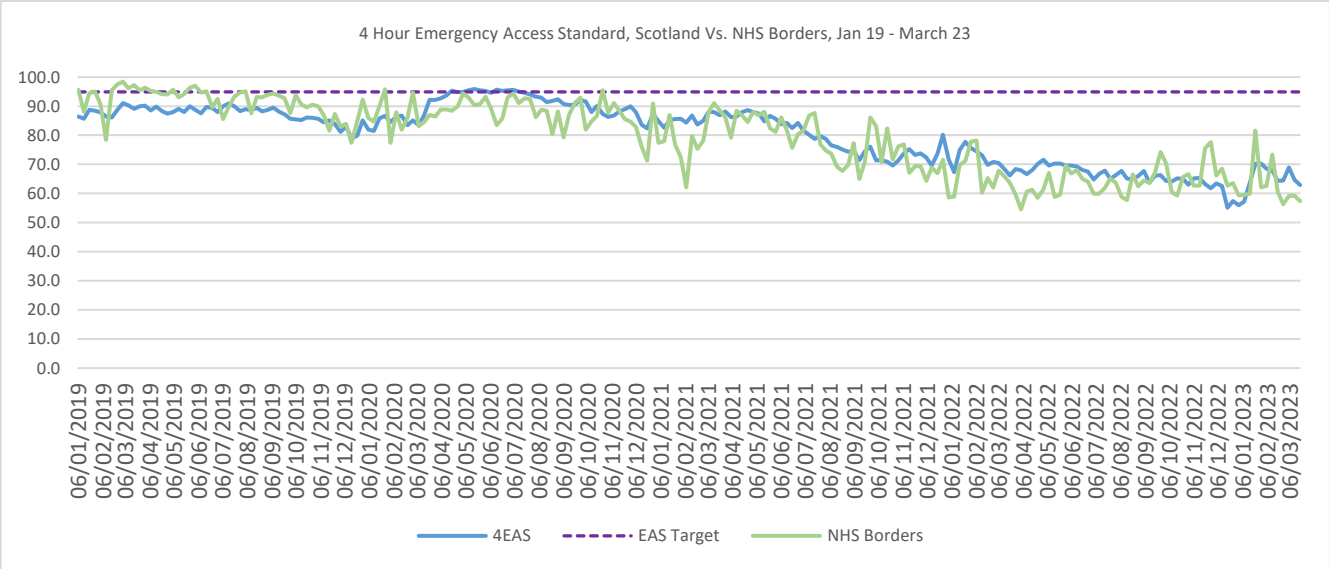


Figure 1 - 4 Hour Emergency Access Standard, Scotland vs. NHS Borders, Jan 19 – March 23

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

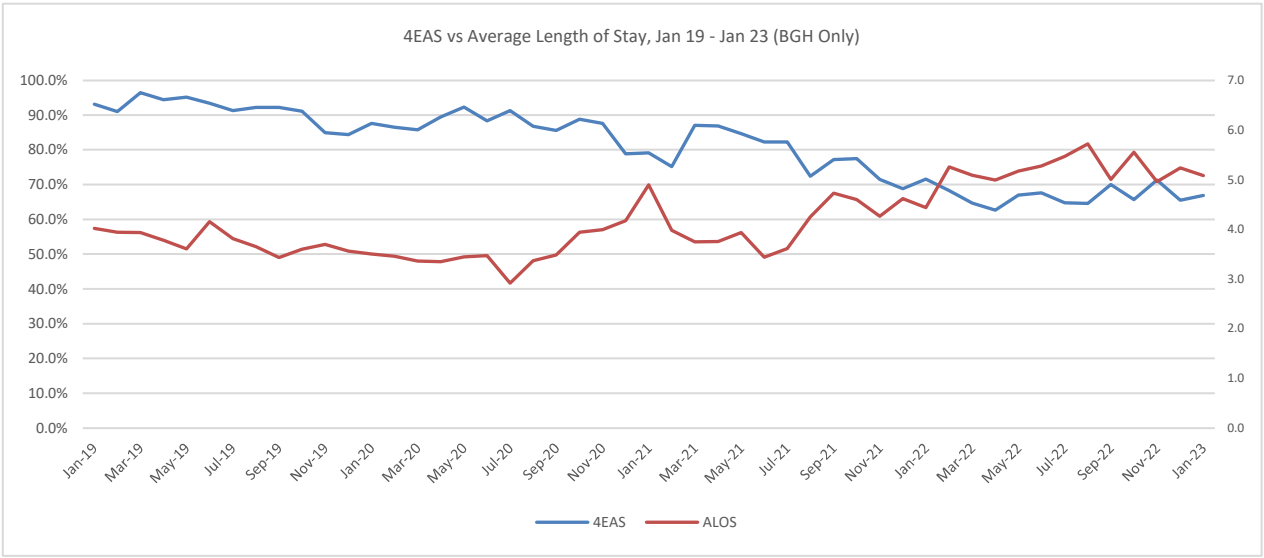


Figure 2 – 4EAS vs Average Length of Stay, Jan 19 – Jan 23

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.

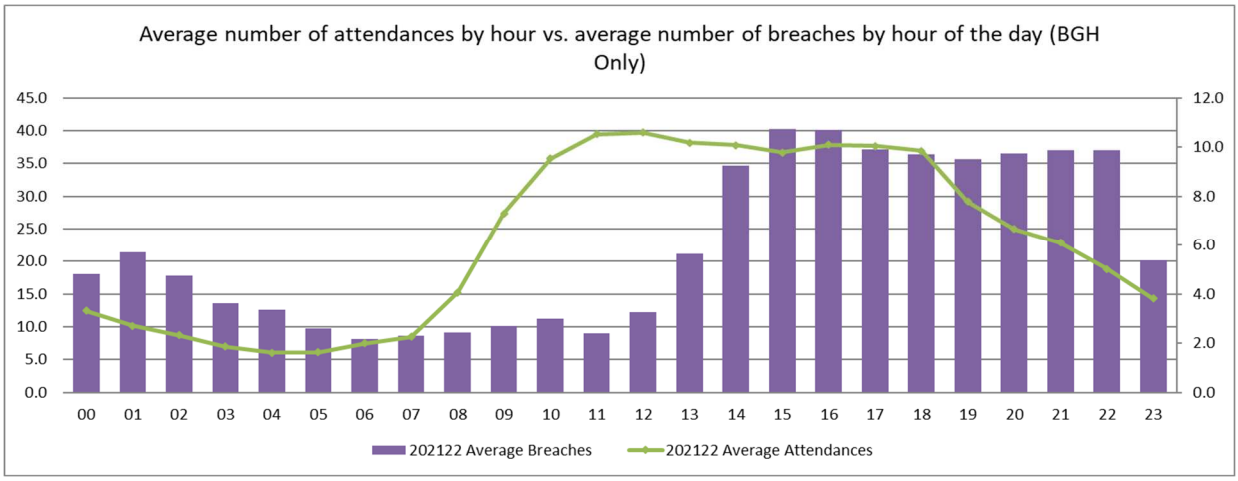


Figure 3 – Average number of attendances by hour vs. average number of breaches by hour of the day

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.

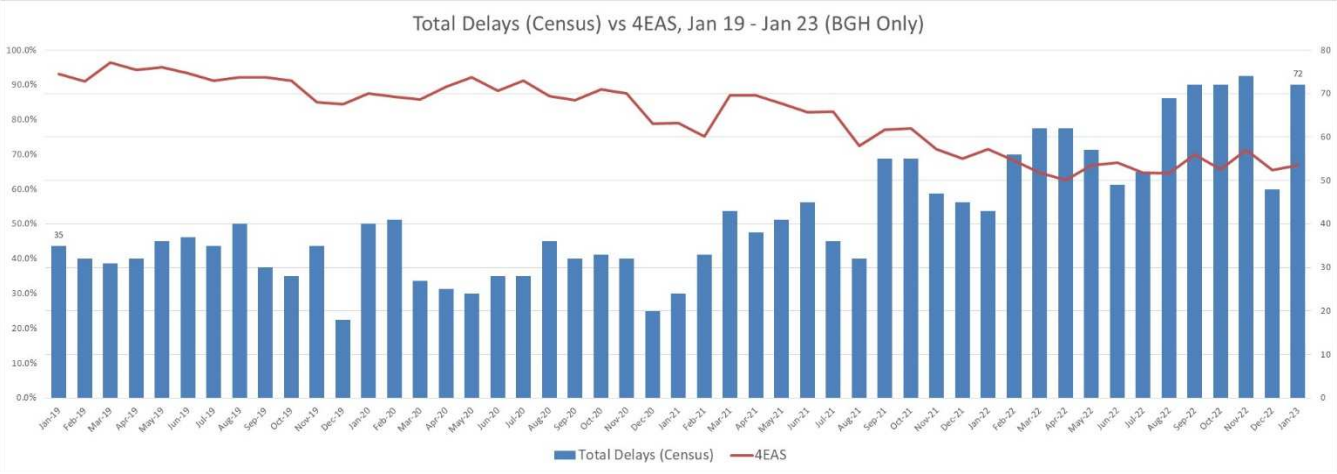


Figure 4 – Total Delays (Census) vs 4EAS, Jan 19 – Jan 23

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):

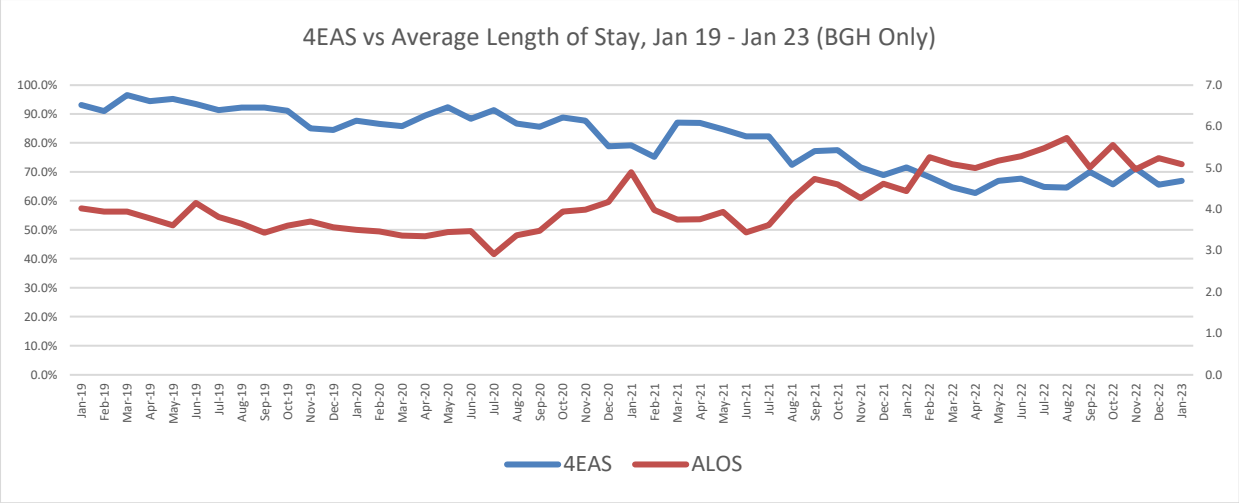


Figure 5 – 4EAS vs. Average Length of Stay Jan 19 – Jan 23

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

1. Amritzer, M.A., Muntlin, Å., Berg, L.M. and Göransson, K.E., 2021. Nursing staff ratio and skill mix in Swedish emergency departments: A national cross-sectional benchmark study. *Journal of nursing management*, *29*(8), pp.2594-2602.
2. Bryan, K., 2010. Policies for reducing delayed discharge from hospital. *British medical bulletin*, *95*(1), pp.33-46.
3. Dall'ora, C., Pope, C., Crouch, R., Sujan, M. and Griffiths, P., 2017. Skill mix and new roles in Emergency and Urgent care: what is the evidence?. *Evidence Brief*, *2*, pp.1-2.
4. Derlet, R.W. and Richards, J.R., 2000. Overcrowding in the nation's emergency departments: complex causes and disturbing effects. *Annals of emergency medicine*, *35*(1), pp.63-68.
5. Gaughan, James, et al. "Why are there long waits at English emergency departments?." *The European Journal of Health Economics* 21 (2020): 209-218.
6. Masic, I., Miokovic, M. and Muhamedagic, B., 2008. Evidence based medicine-new approaches and challenges. *Acta informatica medica: AIM: journal of the Society for Medical Informatics of Bosnia & Herzegovina: casopis Drustva za medicinsku informatiku BiH*, *16*(4), pp.219-225.
7. Mather, K. and Seifert, R., 2017. Heading for disaster: Extreme work and skill mix changes in the emergency services of England. *Capital & Class*, *41*(1), pp.3-22.
8. Recio-Saucedo, A., Pope, C., Dall'Ora, C., Griffiths, P., Jones, J., Crouch, R. and Drennan, J., 2015. Safe staffing for nursing in emergency departments: evidence review. *Emergency Medicine Journal*, *32*(11), pp.888-894.
9. Robinson, K.S., Jagim, M.M. and Ray, C.E., 2005. Nursing workforce issues and trends affecting emergency departments. *Nursing Management*, *36*(9), pp.46-53.
10. Sibbald, B., Shen, J. and McBride, A., 2004. Changing the skill-mix of the health care workforce. *Journal of health services research & policy*, *9*(1_suppl), pp.28-38.
11. Wolf, L.A., Perhats, C., Delao, A.M., Clark, P.R. and Moon, M.D., 2017. On the threshold of safety: A qualitative exploration of nurses' perceptions of factors involved in safe staffing levels in emergency departments. *Journal of emergency nursing*, *43*(2), pp.150-157.
12. Hassan, M., Tuckman, H.P., Patrick, R.H., Kountz, D.S. and Kohn, J.L., 2010. Hospital length of stay and probability of acquiring infection. *International Journal of pharmaceutical and healthcare marketing*, *4*(4), pp.324-338.

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.

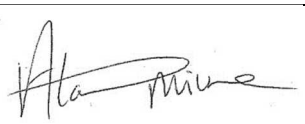
It is well documented that use of Bank and Agency can be detrimental to patient care and using permanent staff to work additional hours can have a negative impact on staff well being e.g. fatigue of working in department already under pressure. Staff unfamiliar with the department can also add to the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

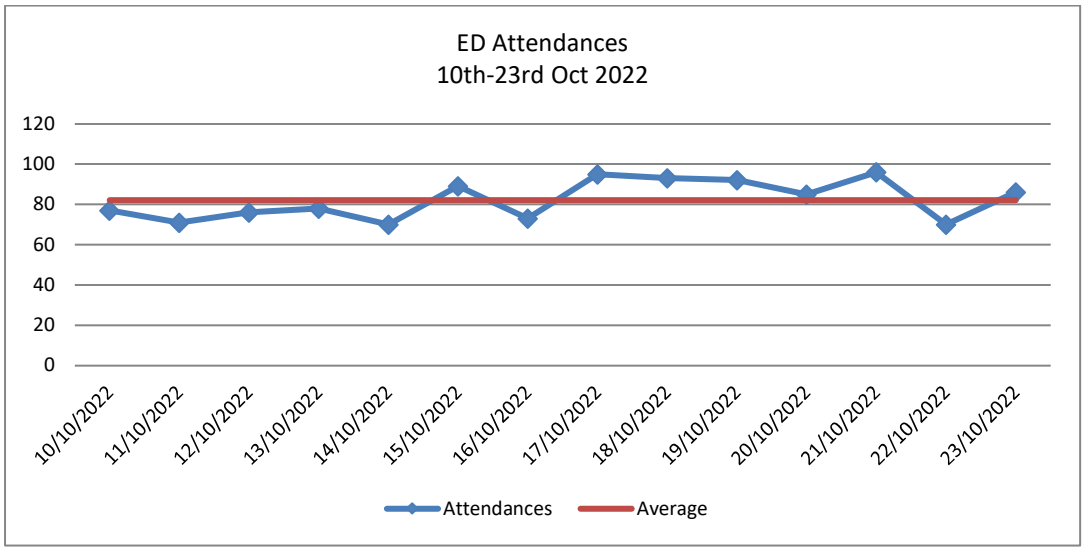
Current ED rota for paper.xlsx

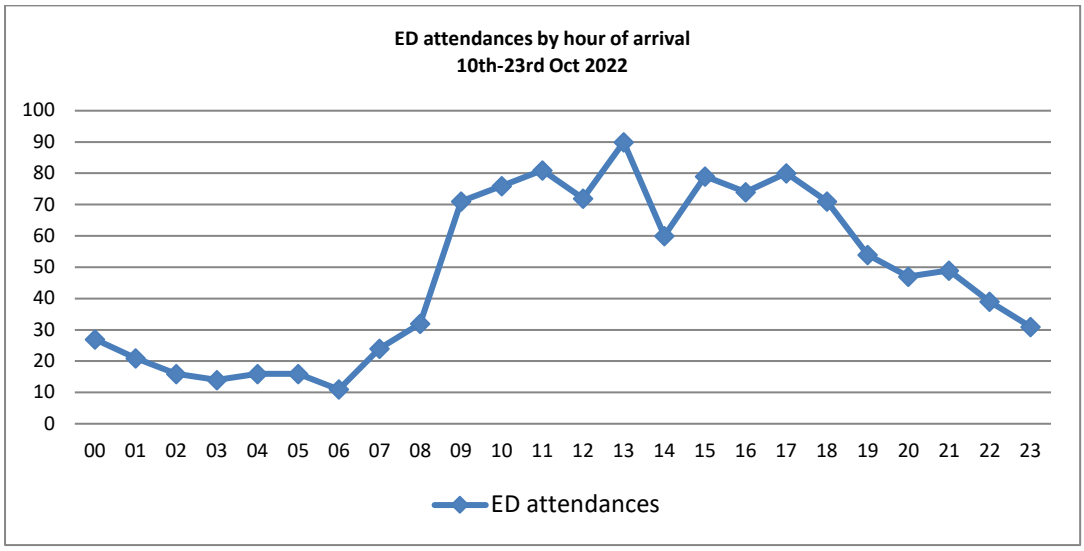
9.6 Appendix 6 – Activity Breakdown during Workforce Tool

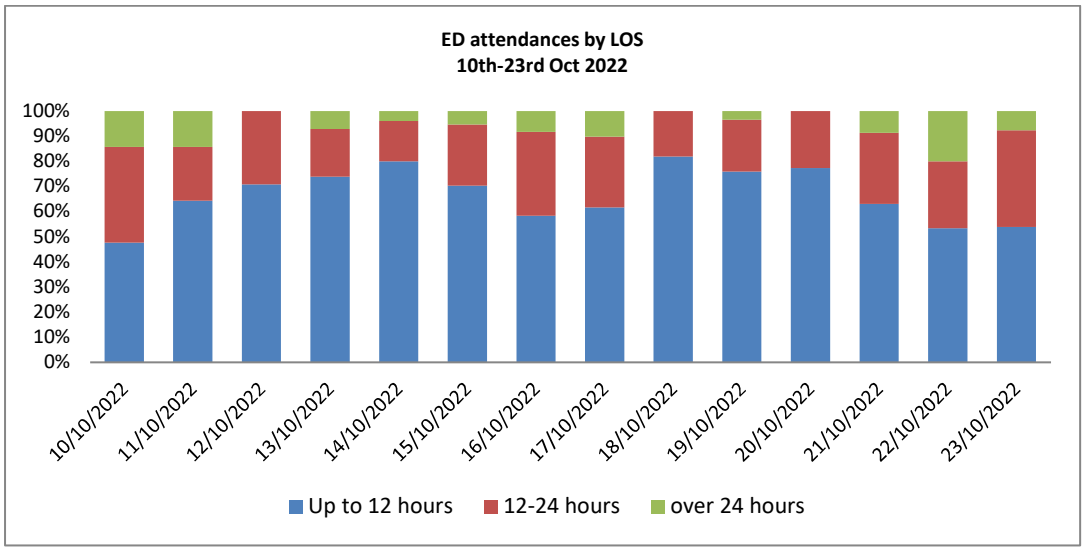
The workload and professional judgment tool was carried out in from 10th to 23rd October 2022 and involved both the nursing and medical team. The following operational pressures were observed:

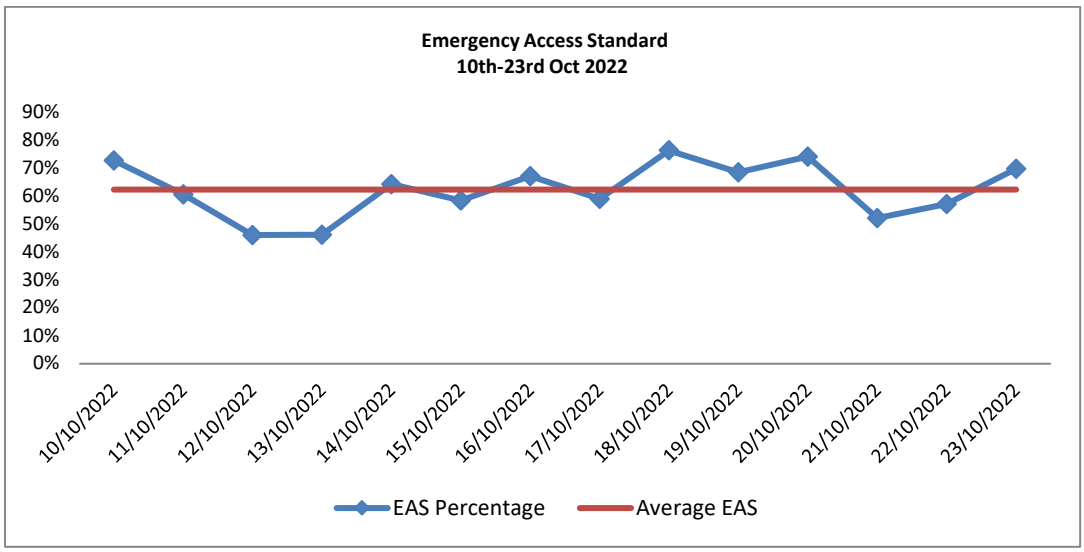
			Staffing Gaps at 8.30am		
Date	**Patients in Department at 8.30am**	**Patients Awaiting Admission at 8.30am**	**RGN**	**HCSW**	**RAG Status**
10/10/2022	18	11	1	1	
11/10/2022	20	12	2	1	
12/10/2022	18	7	2	2	
13/10/2022	21	12	1	2	
14/10/2022	25	12	2	2	
15/10/2022	8	5	1	1	
16/10/2022	16	9	1	0	
17/10/2022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

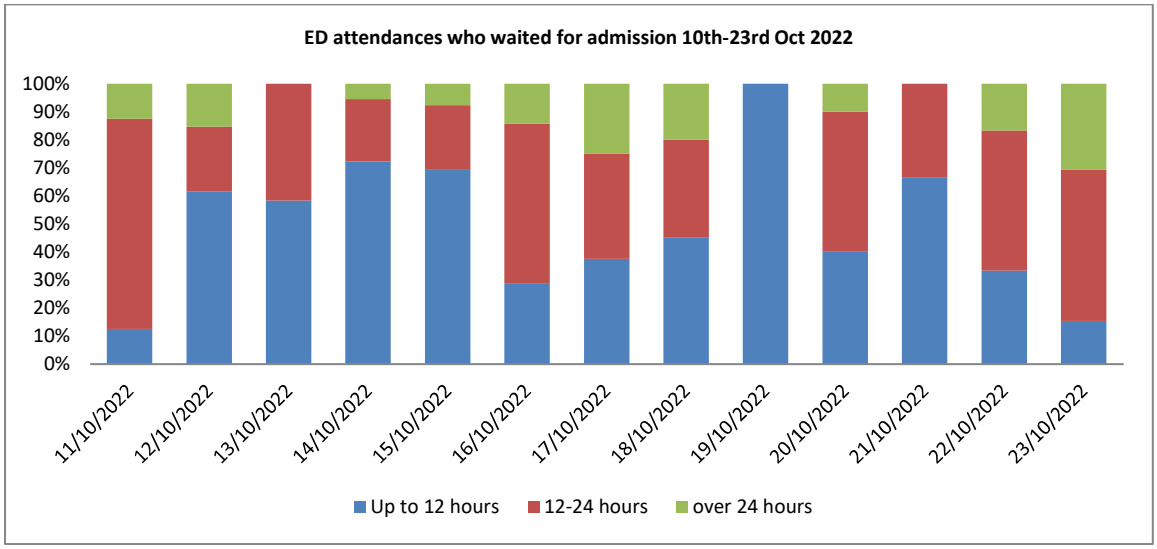
Over the course of the recording weeks, weekly attendances were considered average at 535 and 611 attendances. During the recording period 4, 8 and 12 hours waits for admission were comparable to the weeks previous with 70 patients both weeks spending 12 hours or more in the department. Breakdown of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

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1st August 2024**
Title:	**Energy Efficiency Grant – Procurement Requirements**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Andrew Bone, Director of Finance**

1 Purpose

This is presented to the Board for:

- Decision

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 Health Board is asked to approve by homulgation the contract award and issue of purchase order to Vital Energi Utilities Limited in relation to the Board's capital grant funded energy efficiency programme.

2.2 Background

The Board's Net Zero Carbon Roadmap was presented to the Resources & Performance Committee at its meeting on 2nd November 2023 as part of a wider update on Climate Emergency & Sustainability. This roadmap sets out the actions required to deliver a net zero emissions footprint for the Health Board in line with Scottish Government targets.

In parallel with the development of this roadmap the Board received pre-capital grants for £50,000 per annum in 2022 and 2023 to undertake a detailed assessment of the potential actions required across the estate. The output of this assessment was the

preparation of individual reports for each property held by NHS Borders outlining opportunities for improved energy efficiency, setting out costs and benefits for each action including potential emissions reduction and revenue payback on capital investment.

Following this assessment, an application was made to the Scottish Government Energy Efficiency Grant scheme seeking capital funding to undertake a first phase of actions arising from the report. Application was limited by overall value, scope of activities covered by the grant, and the timescales for delivery.

The grant application covered actions proposed for Border General hospital estate, with some minor elements covering other sites, and prioritised those actions which provided best value in relation to emissions reduction and payback on investment. The total value of this bid was £2.0m. This was subsequently amended to £1.9m following initial review by the grant awarding body which removed minor elements from the scope prior to approval.

The Board was notified of the success of this grant application at its meeting on 1st February 2024.

It is intended to prepare a separate bid in 2025/26 to cover community estate. Early discussion is underway with Scottish Borders Council colleagues to consider feasibility of a joint bid.

Scottish Central Government Energy Efficiency Grant scheme

The Scottish Central Government Energy Efficiency Grant scheme offers capital grant funding support to enable the delivery of heat decarbonisation and energy efficiency projects across the public sector. This funding is targeted towards Scottish central government organisations that have previously had limited access to borrowing funds for this type of work. NHS Boards are not permitted to undertake borrowing to finance capital projects.

Since the scheme launched in June 2021, over £40 million of Capital grant funding has been committed to heat decarbonisation and energy efficiency projects.

Grant awards are subject to performance conditions set by the scheme. This includes milestone deadlines for completion of key stages. For NHS Borders the grant requires that expenditure phasing is as follows:

2024-2025	£1,674,294
2025-2026	£272,560
	£1,946,854

Procurement Arrangements

The scheme requires that participants undertake contracting in line with Scottish Government procurement procedures.

Following approval of the grant application NHS Borders were required to undertake procurement under the Scottish Government Non-Domestic Energy Efficiency (NDEE)

framework contract, which covers all energy efficiency projects with value in excess of £1m, where commissioned through public sector organisations within Scotland.

NHS Borders were advised that tender award must be undertaken by end March 2024 to utilise the existing framework. Thereafter the framework was to be retendered during 2024 and a pause on all projects would be enacted during this period.

This timescale was achieved with tender being issued on behalf of the Health Board through the Scottish Government's appointed energy efficiency contract management team. The framework is now closed and no further contracts will be awarded until such time as a new contract is in place.

2.3 Assessment

Contract award was made to Vital Energi Utilities Ltd for a total value of £1,938,477 (plus VAT) under the procurement arrangements outlined above.

The contract includes upgrade and replacement of plant including pipework insulation, heat distribution improvements, optimisation of Building Management System (BMS), retrofit of air handling unit EC Fans and Chiller Condenser Fans, installation of LED lighting, and implementation of Ground solar panelling on BGH campus (location subject to planning permission).

Board Governance

The normal procurement requirements set out in the Board's Code of Corporate Governance require that a tender award for capital works with a value in excess of £500,000 and approval of purchase orders with a value in excess of £250,000, where pertaining to established contracts, require Board approval[1].

The Code does however outline the following in relation to Scottish Government directions: "Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders"[2].

In this instance, the Grant awarding body, i.e. Scottish Government, have set specific direction on the procurement process to be undertaken following successful grant award. NHS Borders has fully complied with the process as set out by Scottish Government.

Contracts were exchanged on 21st June 2024. The contract was signed on behalf of NHS Borders by the Director of Finance.

A purchase order has subsequently been raised to the contractor for the full value of the contract.

The Health Board is asked to retrospectively approve the contract award, recognising the governance arrangements in place to oversee procurement through Scottish Government.

[1] Code of Corporate Governance, Section F – Reservation of Powers and Delegation of Authority: Section 4.2 - Schedule of Delegated Limits and Authorised Signatories | Quotations, Tendering & Contract Procedures
[2] Code of Corporate Governance, Section B – How Business is Conducted: Para 1.3.

2.3.1 Quality/ Patient Care

The planned works will improve energy efficiency in the Borders General Hospital and other subsidiary locations. Improvement to building management systems and air handling units will enhance environmental controls and should therefore have a positive impact on staff working environment.

2.3.2 Workforce

Per above.

2.3.3 Financial

The capital investment cost of the programme is £1.9m (ex VAT). This is fully funded by capital grant. Programme management will be undertaken by the existing NHS Borders Capital Planning and Estates teams without additional expenditure.

There is a projected recurring revenue saving arising from this project, estimated at £150-200k. Actual figures will be confirmed following review of actual energy performance post-installation. This saving is expected to be achieved in financial year 2025/26.

2.3.4 Risk Assessment/Management

Programme risk is managed through the capital planning team project risk register. There are no high or very high risks identified for the project at this stage.

2.3.5 Equality and Diversity, including health inequalities

Climate change has been highlighted as a public health emergency and the differential impact across the planet is a significant cause of health inequalities. This capital investment will support the wider aims of Climate change mitigation and therefore is expected to contribute to a reduction in health inequalities.

An impact assessment has not been completed because it is not required.

2.3.6 Climate Change

Mitigation of climate change impact is the main focus of this programme. There are detailed KPIs set out in the programme which describe the expected impact in terms of reduction in energy waste and usage, and consequent reduction in net carbon emissions.

2.3.7 Other impacts

This programme aligns with replacement of some existing plant which would otherwise require separate capital investment to ensure the sustainability of the BGH estate, including addressing backlog maintenance and life cycle replacement.

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.

- N/A

It should be noted that a planning application has been submitted for the installation of solar PV panels on the BGH campus. This application will be subject to public consultation.

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.

- None

2.4 Recommendation

- **Decision** – Reaching a conclusion after the consideration of options.

Health Board members are requested to retrospectively approve the contract award to Vital Energi Utilities Ltd for a total value of £1,938,477 (plus VAT), noting that procurement has been undertaken on behalf of the Health Board through the Scottish Government's NDEE framework.

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- None

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 August 2024**
Title:	**Final Patient's Private Funds Accounts 2023/24**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Susan Swan, Deputy Director of Finance (Head of Finance)**

1 Purpose

This is presented to the Committee for:

- Decision

This report relates to a:

- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The Board is recommended, by the Audit & Risk Committee, to approve the Annual Accounts for Patients' Private Funds.

2.2 Background

The Annual Accounts for Patient's Private Funds are included for consolidation within the Health Board's group accounts, which were approved at Health Board on 27th June 2024.

The Patient's Private Funds were reviewed by the Audit & Risk Committee at its extra-ordinary meeting on 27th June 2024 however due to timescales for issue of Board papers it was not possible to present the final version of the funds accounts to the Board for approval on that date.

Due to the value of the funds and their immateriality on the Health Board's group accounts the Audit & Risk Committee were able to recommend the group accounts for approval to the Board meeting on 27th June. This position was endorsed by the External Audit Lead who was satisfied that the draft Patient's Private Funds accounts presented for audit were sufficient to inform the overall audit opinion of the Health Board's group accounts.

At the extraordinary meeting of the Audit & Risk Committee it was agreed that the Patients' Private Funds accounts would be presented to the next available Board meeting on 1st August 2024.

2.3 Assessment

The preparation of accounts for patients' private funds is a requirement of Health Boards through the NHS Scotland Act (1978).

The accounts are prepared in line with relevant accounting standards and guidance. The appointed auditors, Thomson Cooper Accountants, have provided a clean audit opinion and their report is included within the Accounts as an appendix to this paper.

2.3.1 Quality/ Patient Care

There are no relevant issues to report in relation to the above topic.

2.3.2 Workforce

There are no relevant issues to report in relation to the above topic.

2.3.3 Financial

The report describes historic expenditure for the accounting period, and opening / closing balances for the period.

2.3.4 Risk Assessment/Management

There are no relevant issues to report in relation to the above topic.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because it is not relevant.

2.3.6 Climate Change

There is no impact to Climate Change from this report.

2.3.7 Other impacts

There are no other relevant impacts identified.

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 recommended to **approve** the Annual Accounts for Patients' Private Funds.

The Committee will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Patients Private Funds Annual Accounts 2023/24

BORDERS HEALTH BOARD

PATIENTS' PRIVATE FUNDS ANNUAL ACCOUNTS

2023/24

BORDERS HEALTH BOARD

PATIENTS' PRIVATE FUNDS
FOR THE YEAR ENDED 31 MARCH 2024

2023		2024
£		£
	RECEIPTS	
	Opening Balances:	
5,169	Cash in Bank	8,801
862	Cash on Hand	713
-	Other Funds	374
6,031		9,888
28,229	From or on behalf of Patients	39,037
34	Interest on Patients' Fund Account	131
34,294	**Total Receipts**	49,056
	PAYMENTS	
24,406	To or on behalf of Patients	44,464
-	Extra Comforts etc.	-
	Closing Balances:	
8,801	Cash in Bank	3,614
713	Cash on Hand	978
374	Other Funds	-
9,888		4,592
34,294	**Total Payments**	49,056
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
9,888	Credit Balances	4,592
-	Less: Debit Balances	-
9,888		4,592
-	Interest Received but not Credited	0
9,888	**Total Closing Balance**	4,592

I certify that the above Financial Statement is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance …… Date ……..

The Financial Statement was submitted at the NHS Board Meeting on and duly approved.

Chief Executive …… Date …….

BORDERS HEALTH BOARD

PATIENTS' PRIVATE FUNDS
FOR THE YEAR ENDED 31 MARCH 2024

NOTES TO THE FINANCIAL STATEMENTS

1 Basis of Preparation

The Scottish Government Health Directorate requires Borders Health Board to prepare, on an annual basis, an abstract of receipts and payments of patients' private funds administered by the Board. The Financial Statement has been prepared in accordance with the requirements of SFR 19.0 of the NHS Scotland Unified Board Accounts Manual.

BORDERS HEALTH BOARD

PATIENTS' PRIVATE FUNDS
FOR THE YEAR ENDED 31 MARCH 2024

Statement of Board Members' Responsibilities

The Scottish Government Health Directorate requires Borders Health Board to prepare an abstract of receipts and payments of Patients' Private Funds for each financial year which fairly present the state of the funds administered.

Borders Health Board is responsible for ensuring proper accounting records are maintained, which disclose with reasonable accuracy at any time the financial position of the Patients' Private Funds and enable it to ensure that the statement complies with the requirements of the Scottish Government Health Directorate given in the NHS Board Manual for Accounts. It is also responsible for safeguarding the assets held on behalf of the patients and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As members of the Borders Health Board we confirm that the above responsibilities have been discharged during the period and in preparing the abstract of receipts and payments.

Director of Finance …… Date ……..

Chief Executive ……. Date ……..

Independent Auditor's Report to the Board of Borders Health Board

We have audited the financial statements of Borders Health Board Patients' Private Funds for the year ended 31 March 2024 set out on page 1. These financial statements have been prepared under the historical cost convention.

In our opinion, the financial statements give a true and fair view of the state of the Funds' Receipts and Payments Account for the year ended 31 March 2024.

Basis of Opinion
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Respective Responsibilities of Health Board and Auditors section of our report. We are independent of the fund in accordance with the ethical requirements that are relevant to our audit of the financial statements of the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion

Respective Responsibilities of Health Board and Auditors
As described in the Statement of Health Board Members' Responsibilities you are responsible for the preparation of the financial statements in accordance with applicable law and United Kingdom Accounting Standards and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK). Those standards require us to comply with the Financial Reporting Council's (FRC's) Ethical Standards for Auditors. Respective responsibilities of Board members and auditors

Use of Our Report
This report is made solely to the Board as a body. Our audit work has been undertaken so that we might state to the Board those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board as a body, for our audit work, for this report, or for the opinions we have formed.

Fiona Haro CA (Senior Statutory Auditor)
Thomson Cooper, Statutory Auditor
3 Castle Court
Carnegie Campus
Dunfermline
KY11 8PB

Date…..……2024

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 August 2024**
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 10 July 2024

2.4 Recommendation

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

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Clinical Governance Committee minutes 29.05.24

Borders NHS Board
Clinical Governance Committee
Approved Minute

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 29 May 2024** at 10am via Microsoft Teams

Present

Mrs F Sandford, Non-Executive Director (Chair)
Mrs H Campbell, Non-Executive Director
Dr K Buchan, Non-Executive Director
Ms L Livesey, Non-Executive Director

In Attendance

Miss D Laing, Clinical Effectiveness Administrator (Minute)
Mrs L Jones, Director of Quality & Improvement
Dr S Bhatti, Director of Public Health
Dr J Manning, Associate Medical Director, Acute Services
Mr M Clubb, Director of Pharmacy
Mrs S Horan, Director of Nursing Midwifery and Allied Health Professionals
Mr P Grieve, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Williams, Associate Director of Nursing, Allied Health Professionals
Mrs K Guthrie, Associate Director of Midwifery & GM for Women & Children's Services
Mr S Whiting, Infection Control Manager

1 Apologies and Announcements

Apologies were received from:

Mr R Roberts, Chief Executive
Mrs L Huckerby, Interim Director of Acute Services
Dr L McCallum, Medical Director
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Dr I Hayward, Associate Medical Director, Acute Services
Dr T Young, Associate Medical Director, Primary & Community Services
Dr A Cotton, Associate Medical Director, Mental Health Services
Mrs E Dickson, Associate Director of Nursing/Head of Midwifery
Mrs L Pringle, Risk Manager
Mrs C Cochrane, Head of Psychological Services
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities

The Chair confirmed the meeting was quorate.

The Chair welcomed:

Rachel Gardiner	Team Manager LD Services	Item 5.2
Gary Ward	Operational Manager Mental Health	Item 5.3
Louise Keir	Consultant Clinical Psychologist	Item 5.3
Bhav Joshi	General Manager, Unscheduled Care	Item 5.6

Announcements:
On behalf of the Clinical Governance Committee the Chair congratulated Lynsey Russell SCN - ITU and Rachel Gardiner, Team Manager – Learning Disability Service, on their well-deserved awards.

2 Declarations of Interest

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

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

3 Minute of Previous Meeting

3.1 The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 13 March 2024 was approved.

4 Matters Arising/Action Tracker

4.1 There were no matters arising from the previous meeting. The action tracker was discussed and updated accordingly.

5 Effectiveness

5.1 Clinical Board update - Primary & Community Services

5.1.1 Mr Grieve provided a brief overview of the report. Concern remained around Community Hospital recruitment, Community Nursing staffing gaps, the position in District Nursing in Eildon and Health Visiting. Mr Grieve informed the Committee that sickness absence rate for Health Visitors (HV) is in fact 17% and not 24% as noted in the paper, he will update the Committee on the Nursery Nurse (NN) absence in next divisional report. Mr Grieve reported the picture is improving. There had been a downward trend in absence and a reduction in outstanding completed return to work paperwork. Direct clinical care had understandably taken precedence over audit collection and appraisals.

5.1.2 Demand for insulin administration within District Nurse (DN) teams had risen, introduction of new policy to cover non registered practitioners will alleviate this.

5.1.3 Dental services remain under pressure with long waiting list for procedures requiring anaesthesia, mitigations in place are noted in the paper.

5.1.4 Increased demand on Allied Health Professions (AHP) had impacted on the quality and ability to meet needs of longer term in-patient rehabilitation largely due to focus remaining on patients ready for discharge. Mr Grieve noted a value based health care approach was being applied. Mr Williams gave an update on work ongoing addressing increased demands within AHP services. Investment in digital solutions and value based health care initiatives are being made to ensure needs are correctly met by appropriate staff. Reduced working week is impacting services, this is being fed back through the Board. The Chair hoped the impact of reduced working week was being fed back to the Scottish Government via the Board.

5.1.5 The Committee discussed difficulties of recording inherited damage correctly in the community partly due to patient flow through the system. Mr Grieve is working closely with Clinical Governance & Quality to get more detail on pressure damage, Mrs Jones noted that data cleansing takes place to distinguish between developed and inherited damage. Ways to improve tissue viability service under consideration. The Chair requested a discussion relating to tissue viability take place out with meeting.

5.1.6 Mrs H Campbell enquired about whooping cough vaccinations following rise in cases Nationally. Mr Grieve commented vaccinations continue but will liaise with vaccination colleagues to establish if there are any Government directives relating to rise. Mr Bhatti informed the committee whopping cough is sporadic, rise in incidence had not been recorded in Borders.

5.1.7 Mrs Horan informed Committee oaf National workforce review in relation District Nursing, Health Visiting, School and Nursery Nursing. This will look at consistency of how these teams are made up across Scotland in how these teams, outcome will be brought back to Committee. Discussion followed regarding Health Visiting absence and vacancies, the Committee encouraged the completion of return to work discussions to support staff more effectively.

5.1.8 Discussion followed in relation to AHP staffing situation which had been misquoted previously. Mrs Jones and Mr Williams confirmed there is not an issue with recruiting, more with turnover and time taken to fill posts due to restrictive vacancy process. This creates a clinical risk in relation to prioritising needs which can be detrimental long term outcomes due to deconditioning and longer stays in hospital. Deconditioning is a topic for the Scottish Patient Safety Programme Nationally giving assurance this will be considered at a local level.

5.1.9 Ms Livesey enquired incomplete return from work interviews and support for those returning to work following sick leave. Mr Grieve assured the committee that in line with attendance policy support is given to those off on long term absence including the interviews which cannot take place until staff member has come back to work.

5.1.10 Mrs Guthrie updated the Committee on pressures effecting paediatric waiting lists and the use of the Day Procedure Unit (DPU), The Chair asked why it was possible for paediatric day case procedures pre covid. Mrs Guthrie commented that as these were now done as day cases in ward 15 as DPU is used more for adults so children could not be seen safety in that environment, there were also issues with staffing DPU appropriately. Paediatric unit is not big enough for this level of activity and potentially children are being displaced because of adult activity. Mrs Jones provided reassurance by sharing information relating to prioritisation of theatre time, noting there had been a positive shift in reducing waiting times and access to theatres.

5.1.11 Ms Livesey also enquired about paediatric waiting times for dental and ENT cases Mrs Horan discussed the issues noting that it was important that the significant increase in need for inpatient dental work should be addressed as this is clearly becoming an issue, Dr Bhatti alluded to public health activities being dependant on health visitors and services already under duress. She requested that the committee look at related data as it might make help make the picture clearer.

5.1.12 Dr Bhatti raised concern that the Committee focussed heavily on training and risk but would like to see more around the other pillars of clinical governance. He is keen that the Committee look at the purpose of services and link reporting back to that. He

noted issues relating to independent contractors do not appear to be given the same weight. Mrs Jones commented GPs and independent contractors had been flagged in our response to Scottish Government. She stations Scotland's approach to the way data is collected from independent contractors means despite efforts being made to address this there are limitations to how NHS Borders Board can influence independent contractors reporting. Mrs Jones and The Chair offered to have discussion with Dr Bhatti and Dr Buchan particularly around the findings of Lucy Letby report. Mr Williams commented that P&Cs are moving to care assurance approach, individual services will be asked to provide assurance around the seven pillars and details will be included in divisional reporting.

5.1.13 ACTIONS:

The Chair, Mrs Jones, Mrs H Campbell and Mrs Horan will discuss tissue viability data and reporting on inherited and developed damage.

Mrs Horan requested that details around increased need for inpatient dental work be included in Annual Dental report.

Mrs Jones, The Chair, Dr Bhatti and Dr Buchan to discuss expanding reports to include all seven pillars of Clinical Governance.

5.1.14 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **limited assurance**

5.2 Clinical Board update – Learning Disabilities Services

5.2.1 Ms Gardiner provided a brief overview of the report. She noted that annual health checks were ongoing and good progress was being made despite some stumbling blocks.

5.2.2 The Coming Home programme was progressing, although a fair amount of work remains to ensure everything is in place. Accommodation continues to be an issue and solutions are being sought. The Chair commented, whilst recognising the complexity of repatriation the Committee were concerned progress had been slow. Discussion followed relating to complexities and contingency planning should arrangements break down. The Committee noted that they would be keen to see this important piece of work progress as quickly as possible.

5.2.3 Following comment from Mrs Jones there was a discussion relating to GPs supporting annual health checks, although funded it appears to be a very extensive and significant amount of work which may not be feasible and solutions not easy to find. Mrs Horan noted the need to ensure people living with a learning disability are not further marginalised in accessing health care.

5.2.4 The Chair commented that the report provided some assurance around movement on Annual Health checks and repatriation albeit slower than would like but recognised that there was a lot of work being put into resolutions.

5.2.5 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **limited assurance.**

5.3 Clinical Board update – Mental Health & Psychological Services

5.3.1 Mr Ward provided a brief overview of the content of the Mental Health report. Demand on Services locally remains high; this is also being seen at National level. He informed the Committee of several nominations for Mental Health Services at recent Celebrating Excellence awards, Mr Ward and the Committee congratulated Gillian Mayer and Jan Moffitt on their awards.

5.3.2 Changes had taken place within the service including amalgamation, opening and relocation of bases with a central office located at BGH. The MHOAS service review had progressed to engaging people with lived experience, this should be completed within the next six months alongside the European Human Rights impact assessment process.

5.3.3 The Border's Addiction Service (BAS) has undergone it's submission for Medical assessment standards (MAT) as in previous years, they've demonstrated further improvement and consistency in standards of care across the Scottish Borders. Consultant recruitment in BAS had been successful. Waiting list initiative should be concluded by end of week and general mental health assessments are awaiting completion.

5.3.4 Children & Adolescent Mental Services (CAMHS)had achieved their HEAT target of patients seen within 18 weeks. This has been a large piece of work which challenged the whole team over the last couple of years. Further work is required on neuro divergent waiting lists with an expectation this will require a whole system response to meet targets. Multidisciplinary group was pulled together and are in the process of agreeing format of group and Terms of Reference.

5.3.5 Borders Specialist Dementia Unit and Huntlyburn had visits from the Mental Welfare Commission receiving glowing reports. Only issues noted related to care planning and record keeping. The reports were appended to end of divisional report.

5.3.6 Challenges and concerns for the service are evident within senior medical staffing, however recruitment of locum doctors has helped bolster the workforce. Significant clinical risk remains but additional admin staff have been put into place to support the medical workforce which should alleviate some of their admin pressures.

5.3.7 Mr Ward noted there was a reduced working week group set up look at the challenges involved in staffing deficits and options due to the reduction.

5.3.7 The FIP programme senior managers have met with executive team and agreed initial savings proposals. The other operations and clinical nurse managers are working through the mandates with regard to getting plans in place for deadline.

5.3.8 Mr Ward informed the Committee that decision had been made to hold a Fatal Accident Inquiry(FAI) relating to Mental Health Services and Learning Disabilities, communication has begun and they will keep the Committee informed. Mrs Jones offered to brief non-executives out with meeting should they require further information regarding the FAI.

5.3.9 Mrs H Campbell enquired about internal waiting times, discussion followed where Mr Ward gave an update on staffing in place to address waiting list issues. Neurodiversity shortfalls were discussed, Mrs Jones suggested a spotlight in subsequent report around neurodiversity and increased demand in relation to

support especially in the light of recent adverse event which Mr Lerpiniere had previously reported to the Committee.

5.3.10 Ms Livesey enquired about how the service was utilising advanced statements following recommendation in Mental Welfare Commission report and if these could be linked in to the realistic/value based care approach. Discussion followed relating to difficulties with advanced statements for patients in BSDU, discussion relating to advanced care planning should be post diagnostic, these conversations can be very difficult and emotional. The Clinical Nurse Manager has picked up on this recommendation to ensure conversations are documented.

5.3.11 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **moderate assurance**

5.3.12 Psychological Services update

5.3.13 Mrs Keir provided a brief overview of the content of the Psychological Services report. She reported a slight decrease in referrals to the service but an increase in meeting the RTT standard. Services remain under significant pressure due to capacity gaps particularly in learning Disability and Borders Addiction Services, recruitment to vacancies had been successful and expected to be in post by end of summer. Maternity leave and sickness absence continues to impact HEAT targets.

5.3.14 Work along with National Psychological Services manager is taking place towards meeting National psychologies specifications, this will be reported in subsequent reports.

5.3.15 Mrs Keir reported positive and constructive feedback is consistently received via RENEW from service users.

5.3.16 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **moderate assurance** recognising the ongoing challenges in workforce.

5.4 Clinical Board update- Acute Services

5.4.1 Dr Manning provided a brief overview of the report, he cited continued pressure with admissions and discharges. Support is ongoing for elective surgery. Waiting times and waits in emergency department remain high. Kaizen work is being repeated to look at improving patient flow at the front door and alternative admission pathways. Access to frailty assessments and pathways are also being re-visited.

5.4.2 Consultant appointments had been made in cardiology and haematology and interviews for ED consultant arranged. Dermatology remains a concern, post is out for advert. Gaps are being seen within Radiology staffing, NHS Borders are working alongside adjacent health boards to find solutions. Women and Children consultant workforce had improved slowly, new consultant is due to start at end of August which will help with addressing waiting times and emergency cover.

5.4.3 Ventilation has now been fixed, Mr Brydon is communicating any learning from ventilation issues to staff, these will be reported to the Committee in due course.

5.4.4 Falls had increased over reporting period, work is ongoing to look at appropriate equipment and education to prevent falls.

5.4.5 Mr Whiting is leading on hand hygiene improvement within the Medical workforce. Dispensers will be replaced in clinical areas later this year.

5.4.6 Mr Joshi gave the Committee an update on improvements taking place at the front door to alleviate pressures on emergency department and improve patient pathways post COVID. A rapid test of change is being planned and paper going to urgent and unscheduled care programme board for approval. Recruitment to underpin and take the GP expected workload out of emergency department will be necessary, this recruitment will sit within the financial envelope.

5.4.7 Discussion followed regarding risks carried in acute services, Mrs Jones gave an overview of these risks and commented it was important we do not accept these as the 'norm', and the Board should be aware improvements relating to flow and bed availability were paramount to whole system flow and easing risks across the health and social care system. Mrs H Campbell also commented that staffing gaps and issues are not normalised either and the Committee should keep close eye on these shortfalls.

5.4.8 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **limited assurance** recognising the risks being carried at all levels.

5.5 Values Based Medicine

5.5.1 Mrs Jones gave the Committee an update on activities associated with values based care, there has been good progress on treatment escalation plans and changes in practice for AHPs and Nursing. Support was noted from Dr Alcorn in DME. Work on updating refhelp is ongoing to ensure reliable referral pathways across primary and secondary care are in place with aspirations to relaunch the platform by end of summer. Work being led by training and development on communication for health ties in to developments being made.

5.5.2 Discussion took place relating to interface group and how the changes are being felt in primary care. Dr Buchan noted that the biggest challenges remain in the area between primary and secondary care and how the Scottish Government will focus on the bigger picture. A paper is anticipated on better definition of interface working and direction of travel.

5.5.3 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **moderate assurance.**

5.6 Stroke services annual report – taken out of sequence

5.6.1 Mr Joshi presented the annual stroke services report. Inability to recruit to specialist nurse post has had an effect on meeting national standards and targets. Development of a stroke outreach nurse in line with other boards had taken place, there were challenges with overall performance bundle, heavily impacted by key measure of access to the stroke unit the outreach nurse will see patients wherever they are. He also highlighted the lack of rehabilitation spaces in community hospitals leaving patients in the stroke unit for longer than necessary. Mr Joshi touched on improvement work highlighted in the paper and informed the Committee a thrombectomy service supported by NHS Lothian is now in place.

5.6.2 Discussion followed on the early discharge support work and the specialist rehabilitation teams required to meet the recommended pathways for stroke, frailty

and orthopaedic patients particularly in the community, Mr Williams stated this would hard to facilitate in Borders. Lack of any intensive rehabilitation facilities mean there are many challenges associated with meeting standards. The Chair commented that this was an opportunity whilst looking at how we utilise community hospitals to ensure provision of a much more robust rehabilitation service particularly for stroke patients.

5.6.3 Mrs H Campbell raised concern around lack of progress being made in improving adherence to stroke pathway. Mrs Jones commented that access to stroke unit and meeting business model expectations of maximum stay of one day are not achievable until patient flow in unscheduled care areas is improved. The Committee felt it would be helpful to have an idea on average how quickly stroke patients are admitted to unit to provide some assurance around compliance with bundle. This would then continue to be highlighted to the board in the context of flow throughout the system. Mr Joshi assured the Committee that information is routinely collected which demonstrates patients don't remain outliers through their journey. Updates will be provided in the acute services divisional report.

5.6.4 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **no assurance** but recognise that there are great efforts being made to improve the situation.

6 Patient Safety

6.1 Infection Control Report

6.1.1 Mr Whiting provided a brief overview of the content of the report. He noted that on page 11 figures 13 relating to community E-Coli the wrong graph had been attached, the narrative is correct and NHSB are not outliers.

6.1.2 He pointed out there had been no targets set relating to infection control by the Scottish Government for this coming year so existing targets will remain until confirmation is received.

6.1.3 Mr Whiting commented they had seen a reduction in service and deterioration in communication since the establishment of the Regional Health Protection Service. The service around supporting risk assessments prior to discharge from Hospital into care homes appears to have been withdrawn. Mrs Horan is convening a meeting with Dr Bhatti and others to explore this further.

6.1.4 Discussion followed Mrs H Campbell's comment around hand hygiene and how disappointing it was to see the acute services rates were deteriorating. Mr Whiting assured the committee they were looking at ways to engage and informing staff including two yearly mandatory training.

6.1.5 Mrs H Campbell also enquired about meeting between other boards and Borders in relation to their ECB rates, Mr Whiting gave a brief update on some of the discussions. The CAUTI group will be working on some of the suggestions received from others.

6.1.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **moderate assurance.**

6.2 Hospital Standardised Mortality Rates (HSMR)

6.2.1 Mrs Jones commented that HSMR remained within normal levels and there was nothing to escalate to the Committee.

6.2.2 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **moderate assurance**

6.3 Mortality Review Annual Report

6.3.1 Mrs Jones provided a brief overview of the report. She pointed out that some of the rates were based on an old denominator to show more proportionate mortality rates. This reflects changes in how patients are being processed. She commented that there are still excess and COVID deaths being seen which is a pattern across the whole country. Using new denominator, excess deaths may not have shown as spikes and not indicative of the way we deliver care, deaths are reviewed and triggers and spikes investigated, themes highlighted had been similar to previously reported with the addition of bed availability and poor care delivered at end of life. This is reflective of levels of delay in the system and boarding out with specialty.

6.3.2 Discussion followed relating to health inequalities, protected characteristics, sex analysis and disease trajectory. Mrs Jones commented that there was more work to look in depth at analysis of these factors and influences to get a better understanding through time on implications to life expectancy.

6.3.3 The chair noted that the rise in mortality should be highlighted to the Board for discussion.

6.3.4 Mrs Jones further commented that deaths in Scottish Borders population had remained fairly stable although we are seeing more patients dying in an inpatient setting when they would have been at home previously and that more work needs to be done to reach the Health and Social Care Partnership aspiration of enabling patients the choice to remain at home to die.

6.3.5 ACTION: The Chair will highlight rise in mortality to the Board.

6.3.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **moderate assurance**

7 Person Centred

7.1 Patient Feedback including SPSO Position

7.1.1 Mrs Jones provided a brief overview of the content of the report, there were no new trends to highlight. Recovery post Covid is taking longer than hoped and demand on frontline staff to respond has increased. Capacity within the Patient Experience team had been extended, reduction in complaints or improvement in response times had not yet been seen. Response time to complaints is driven by legislation which leaves the organisation at risk, this is being closely monitored. Mrs Jones noted an increase in FOI requests was impacting on the team.

7.1.2 Discussion followed following a suggestion from Dr Bhatti about using Patient Reported Outcome Measures (PROMS). Mrs Jones commented that this was used previously in Orthopaedics but the funding from Scottish Government was

withdrawn. There were suggestions to consider developing our own tools, it was agreed that a discussion should take place out with the meeting.

7.1.3 ACTION: Mrs Jones & Mrs Sandford will discuss incorporating or developing in house PROMS with Dr Bhatti

7.1.4 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **moderate assurance**

8 Items for Noting

8.1.1 The CLINICAL GOVERNANCE COMMITTEE noted the following report and Minutes from other Governance Meetings/Committees

Radiology Internal Audit Report

Mental Health Clinical Governance Group 28.02.24
LD Clinical Governance Group Minute 27.03.24
PGC Minute 09.11.24
Public Health Governance Group Minute 25.01.24
Public Protection Committee Minute 26.10.23
Public Protection Committee Minute 23.12.23

9 Any Other Business

There were no further items of competent business to record.

10 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 10 July 2024** at **10am** via Teams Call.

The meeting concluded at 12:17

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 August 2024**
Title:	**Infection Prevention & Control Report – June 2024**
Responsible Executive/Non-Executive:	**Director of Nursing, Midwifery & AHPs**
Report Author:	**HAI Surveillance Lead** **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 reference to the incidence of Healthcare Associated Infections (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

- ***Staphylococcus aureus* Bacteraemia (SAB)**

1.1 NHS Borders had a total of 5 *Staphylococcus aureus* bacteraemia (SAB) cases in April 2024, 3 of which were healthcare associated infections.

1.2 The Scottish Government previously 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).

1.3 Our predicted target for 2023/24 equated to no more than 20 healthcare associated SAB cases. We tentatively met this target but are still awaiting ARHAI Scotland publication of Q1 2024 epidemiological data in July 2024 which will confirm total occupied bed days and cases for the period and our rate will then be adjusted accordingly.

1.4 We are awaiting updated Scottish Government targets for 2024/25. Until then, we will continue to use our 2023/24 target as illustrated in Figure 1 below.

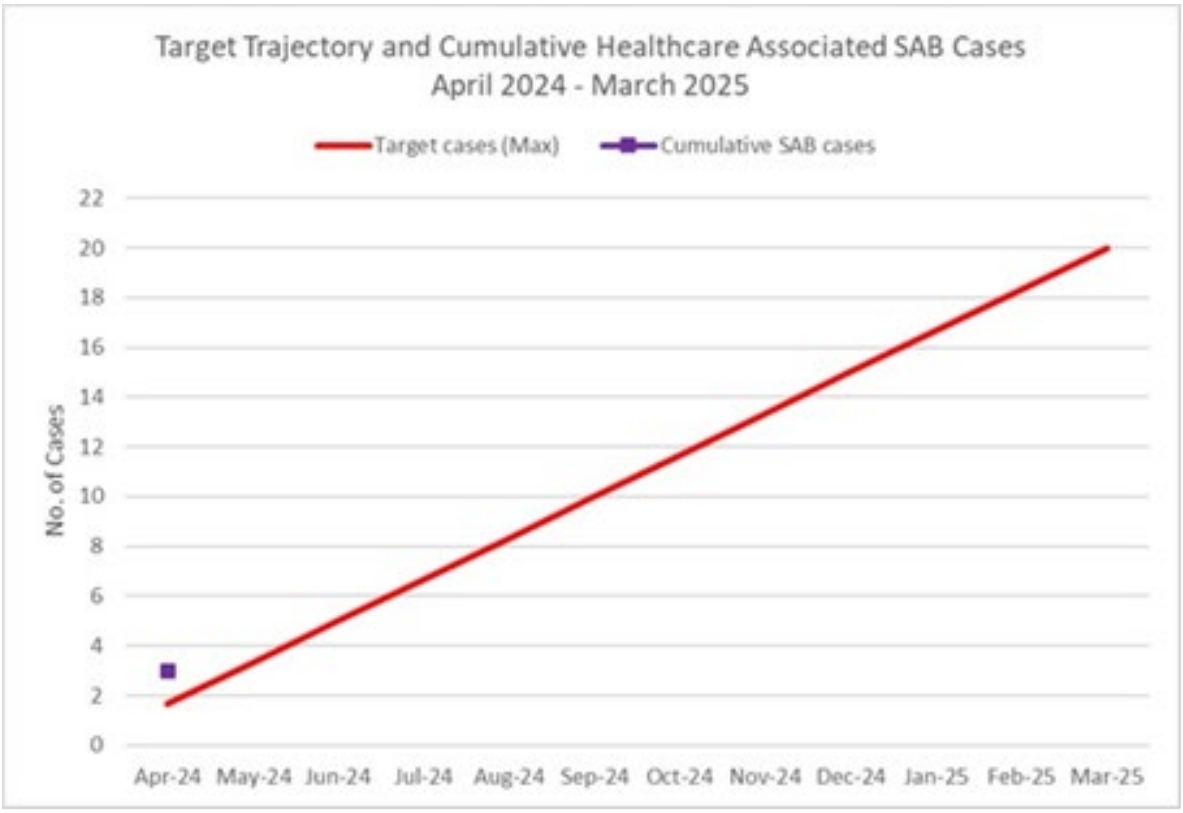


Figure 1: SAB Scottish Government target trajectory and cumulative NHS Borders healthcare associated SAB Cases

- ***Clostridioides difficile Infection (CDI)***

1.5 NHS Borders had a total of 2 *C. difficile* Infection (CDI) cases in April 2024; 1 of which was a healthcare associated infection.

1.6 As with SABs, the Scottish Government set a target for each Board to achieve a 10% reduction in the healthcare associated CDI rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline).

1.7 Our predicted target for 2023/24 equates to no more than 12 healthcare associated CDI cases. We have tentatively not achieved this target but we are awaiting ARHAI Scotland publication of Q1 2024 epidemiological data in July 2024 which will confirm total occupied bed days and cases for the period. Our rate will then be adjusted accordingly.

1.8 We are awaiting updated Scottish Government targets for 2024/25. Until then, we will continue to use our 2023/24 target as illustrated in Figure 2 below.

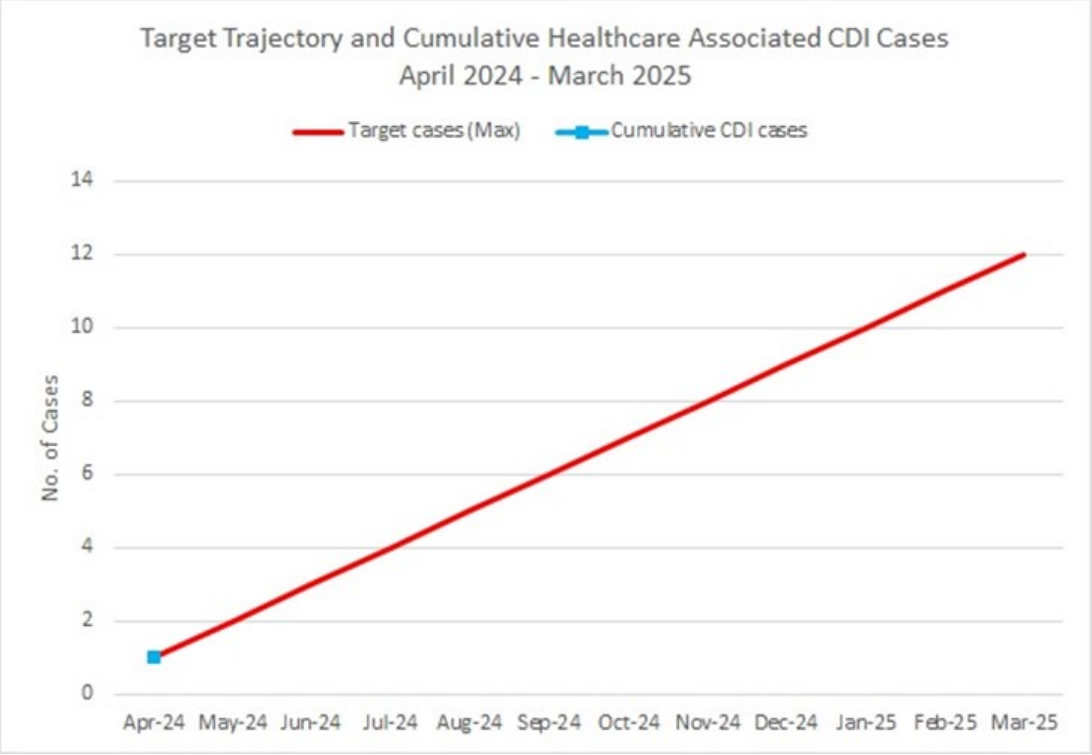


Figure 2: Scottish Government target trajectory and cumulative NHS Borders healthcare associated CDI cases

- **Escherichia coli bacteraemia (ECB)**

1.9 NHS Borders had a total of 8 *Escherichia coli* bacteraemia (ECB) cases in April 2024, 2 of which were healthcare associated infections.

1.10 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). Our predicted target for 2023-24 equates to no more than 32 healthcare associated ECB cases. We did not achieve this target.

1.11 We are awaiting updated Scottish Government targets for 2024/25. Until then, we will continue to use our 2023/24 target as illustrated in Figure 3 below.

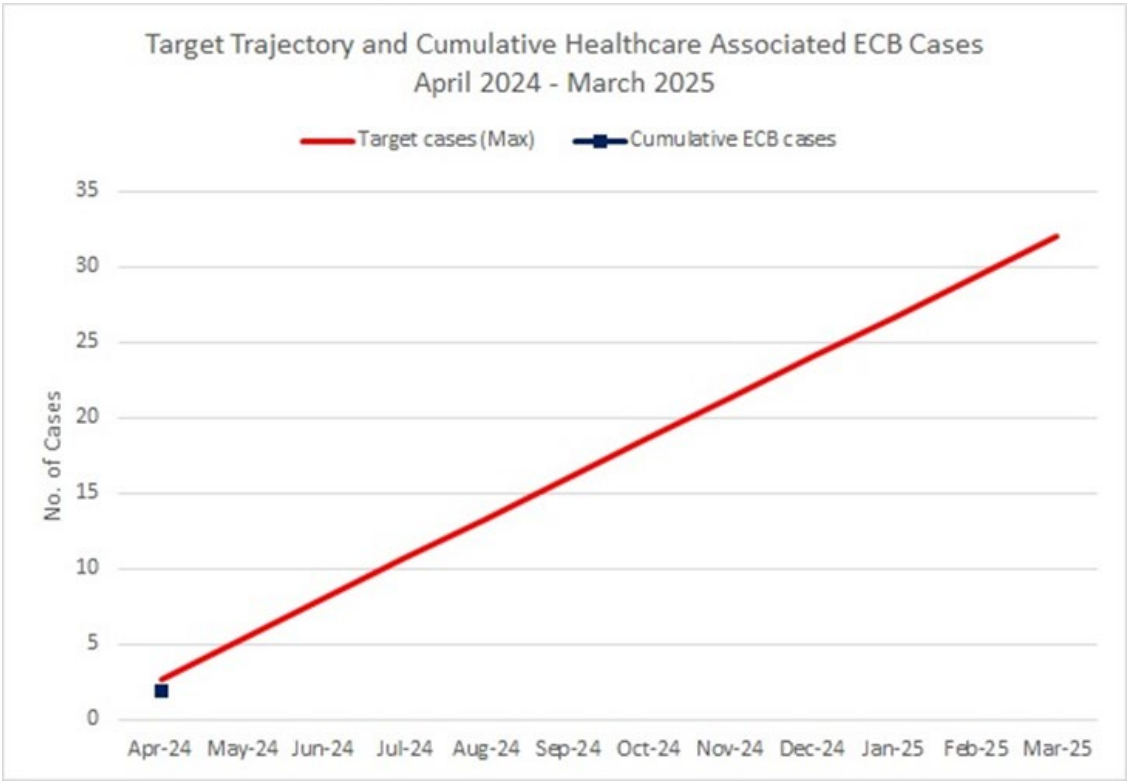


Figure 3: Scottish Government target trajectory and cumulative NHS Borders healthcare associated ECB Cases

2.0 Infection Surveillance

- ***Staphylococcus aureus* Bacteraemia (SAB)**
  (Background information provided in Appendix A)

2.1 All of the 5 SAB cases reported in April 2024 were Meticillin-sensitive *Staphylococcus aureus* (MSSA).

2.2 Figure 4 shows a Statistical Process Control (SPC) chart showing the number of days between each healthcare associated 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.

2.4 In interpreting Figure 4, 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 The graph shows that there have been no statistically significant events since the last update.

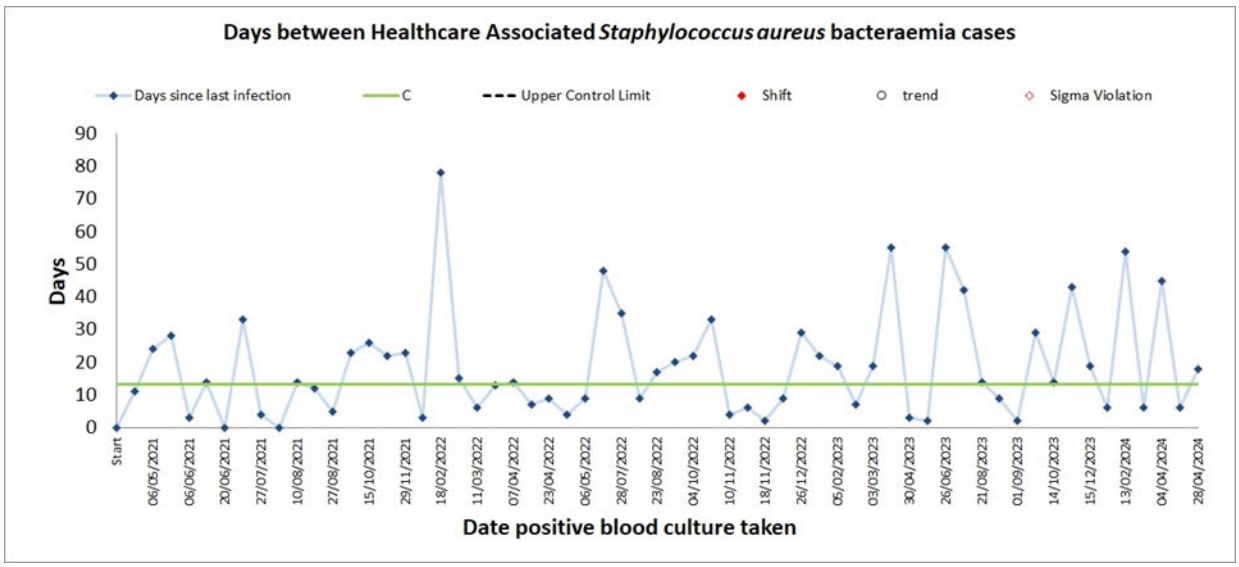


Figure 4: NHS Borders days between healthcare associated SAB cases (May 2021 – April 2024)

2.6 Over the last 2 years, the primary cause of preventable healthcare associated SAB cases has been Catheter Associated Urinary Tract Infection (CAUTI) followed by peripheral vascular cannulas (PVCs) as shown in figure 5 below.

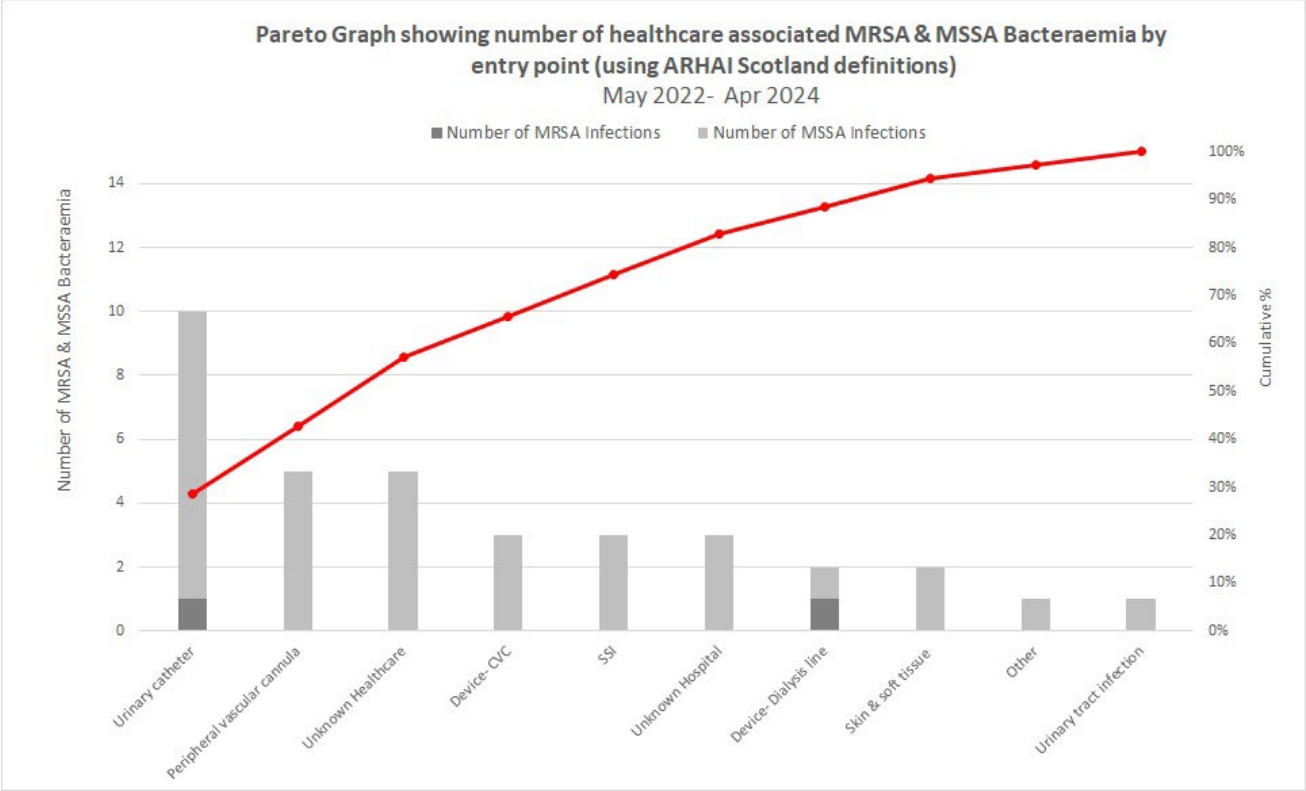


Figure 5: Pareto chart of NHS Borders healthcare associated SAB cases by entry point (May 2022 – April 2024)

- ***Clostridioides difficile Infection (CDI)***
  (Background information provided in Appendix A)

2.11 Figure 6 below shows a Statistical Process Control (SPC) chart showing the number of days between each healthcare associated 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.

2.12 The graph shows that there have been no statistically significant events since the last update.

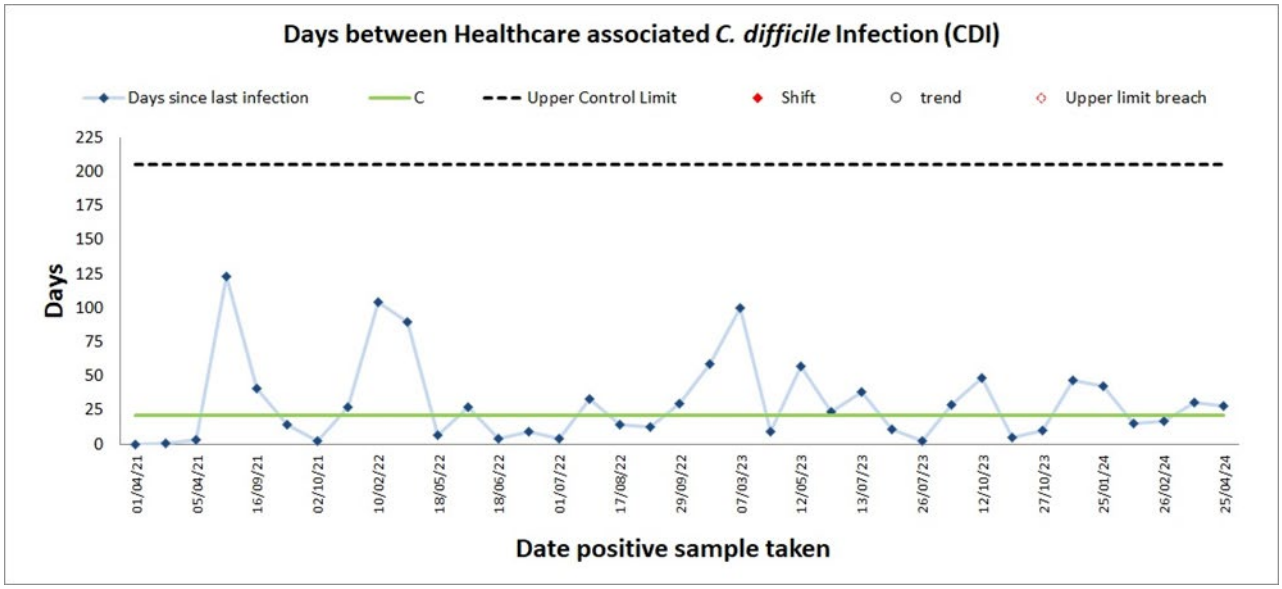


Figure 6: Days between healthcare associated CDI cases (April 2021 – April 2024)

- ***Escherichia coli* bacteraemia (ECB)**
  (Background information provided in Appendix A)

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

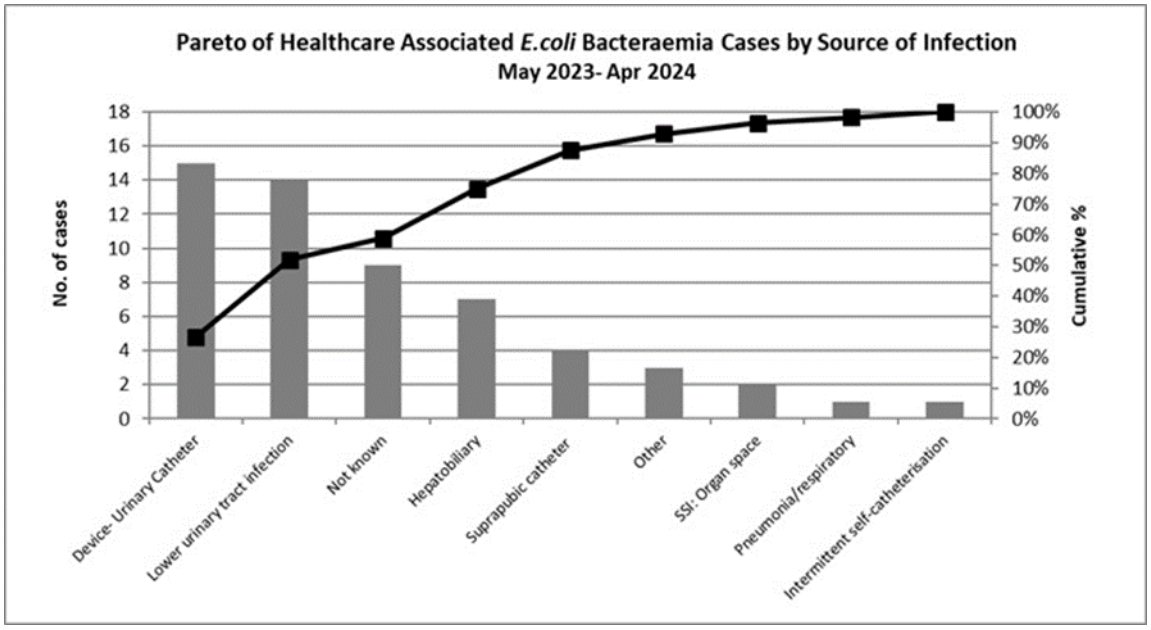


Figure 7: Pareto chart of healthcare associated ECB cases by source of infection

2.14 Figure 8 shows a statistical process control chart of the total number of healthcare associated *E.coli* bacteraemia 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.

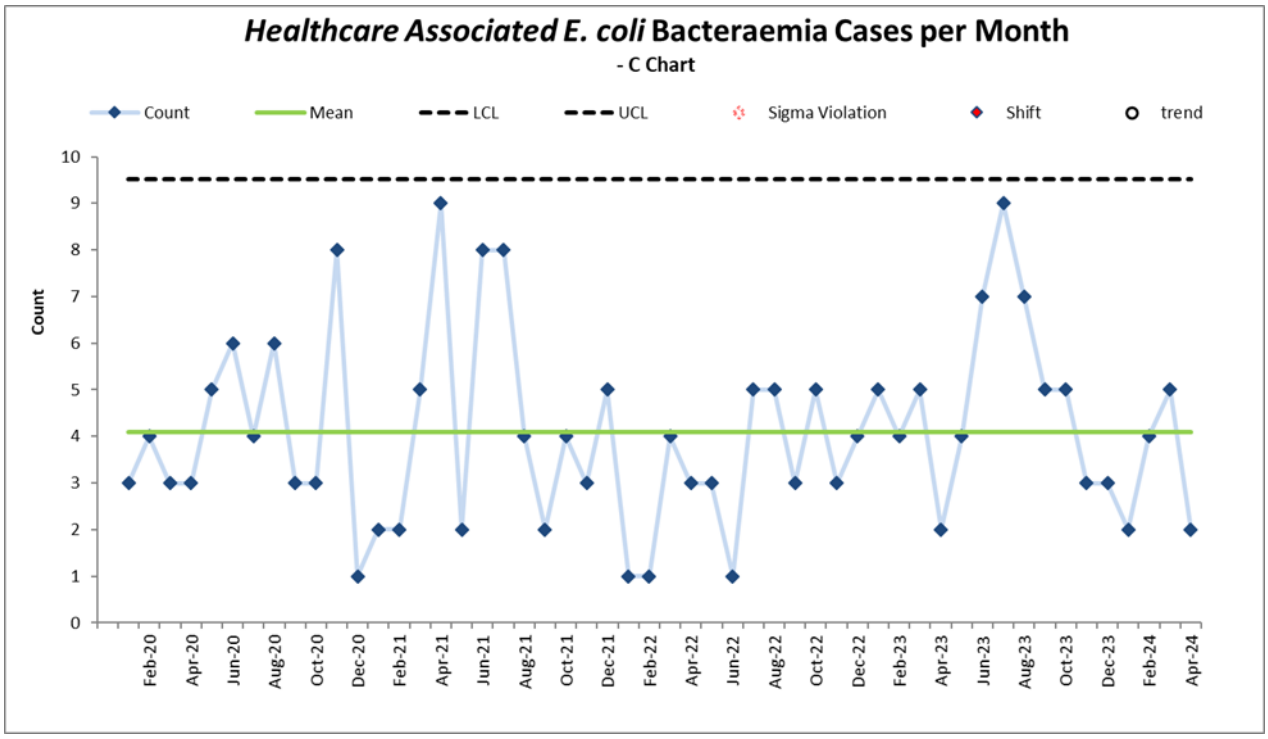


Figure 8: Statistical process chart (SPC) of healthcare associated *E.coli* bacteraemia cases per month (Jan 2020-Apr 2024)

3.0 NHS Borders Surgical Site Infection (SSI) Surveillance

3.1 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.

3.2 In July 2023 NHS Borders resumed local SSI surveillance for hip and knee arthroplasty and C-section surveillance was recommenced in January 2024. The latest data is provided in the tables below. Figures 9 and 10 show statistical process charts (G-charts) which plot the number of surgical procedures between infections. The reason for using this type of chart is to account for fluctuations of the case load due to cancellations or other external factors. The higher the line on the graph, the better we are performing.

Table 1

Summary of Surgical Site Infection (SSI) cases (Using ARHAI Scotland definitions) **(Jan - Apr 2024)**			
Procedure	**Total ops**	**Total SSIs**	**SSI Rate**
Hip arthroplasty	39	0	0.00%
Knee arthroplasty	35	1	2.86%
C-section	99	2	2.02%

Table 2

SSIs per month with category of infection (Using ARHAI Scotland definitions) (Jan - Apr 2024)		
Procedure	**Month**	**SSI category**
C-section	January	Superficial
Knee arthroplasty	February	Superficial
C-section	March	Superficial

NB: Official SSI rates are based on a 12-month period, therefore the data presented in the table is not directly comparable to any previously published pre-pandemic data.

3.3 An Orthopaedic SSI Task and Finish Group has completed a review of the post-operative patient pathway against national guidance. The Infection Control Committee has requested to see the resulting action plan and progress report from this review.

3.4 Infection Prevention and Control continue to meet with the Associate Director of Midwifery/General Manager for Women & Children Services and the Clinical Director to identify and progress actions to reduce the risk of SSI following C-section. Confirmed SSIs are also reviewed by the Core Management Team. An action plan and progress report will be presented to the next meeting of the Infection Control Committee.

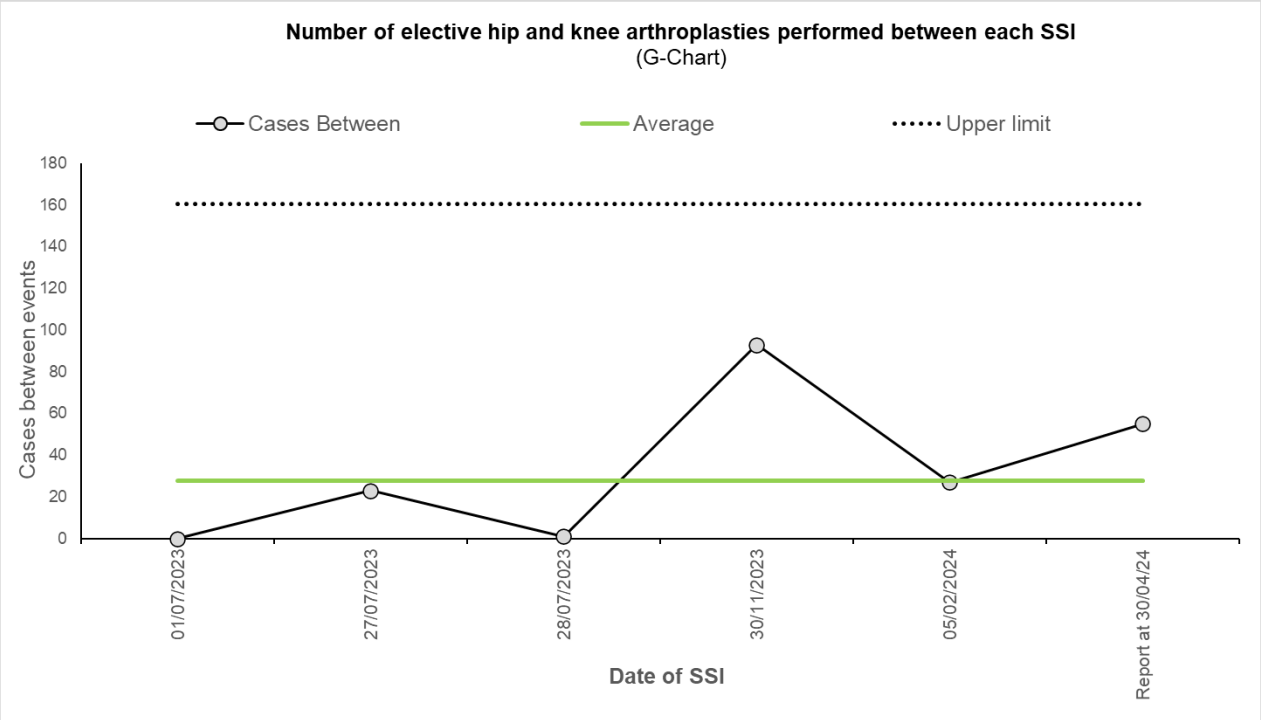


Figure 9: G-chart of elective hip and knee arthroplasties performed between each SSI

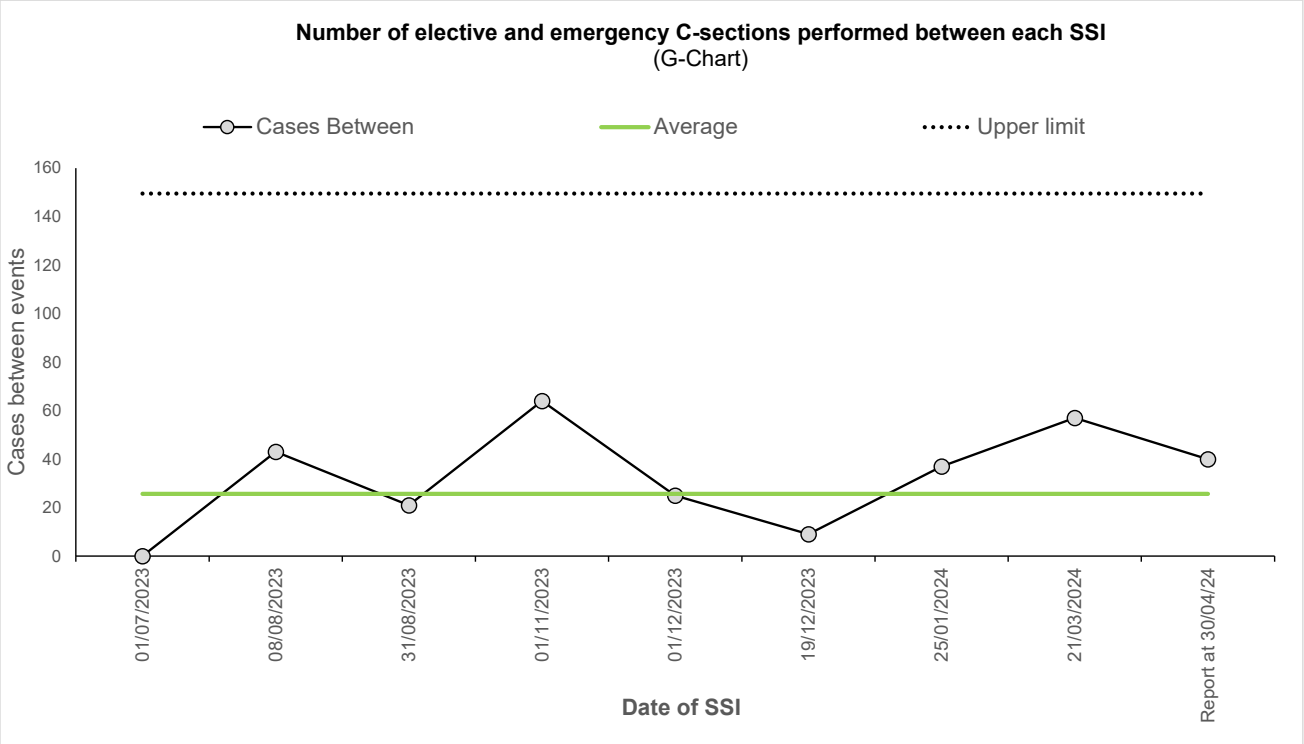


Figure 10: G-chart of C-sections performed between each SSI

4.0 Incidents and Outbreaks

- **Respiratory outbreaks**

4.1 Since the last Board update, there have been 5 respiratory 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 20th June 2024 is detailed in Appendix B.

4.2 Any learning from each incident is captured and acted upon in real time where appropriate.

- **Norovirus**

4.3 There have been no Norovirus incidents since the last Board update.

5.0 Infection Control Compliance Monitoring Programme

5.1 In May and June 2024 spot checks were only undertaken in 3 clinical areas due to full Infection Prevention and Control (IPC) audits being prioritised. Average compliance for these 3 areas was 85.2%.

5.2 The new audit programme for 2024/25 commenced in April 2024. 11 areas were audited in May and June 2024 and all achieved ≥91% compliance. Areas that achieve 99% and above are awarded a certificate of achievement and a small prize.

5.3 Infection Prevention & Control (IPC) review themes from spot checks and audits on a monthly basis and identify improvement actions.

6.0 Quality Improvement Update

6.1 The Prevention of CAUTI Group last met on 11th June 2024 and continues to oversee progress against the action plan and review data at each meeting to consider additional areas for improvement.

6.2 The group has just completed a one-off catheter count across acute, community hospitals, mental health and district nursing teams. This is to identify all patients/service users with a catheter and reason for the catheter. This work will highlight areas with higher catheter use and potential requirements for support in relation to management and documentation.

6.3 A short life working group has developed a hydration campaign which commenced during June 2024. This is to remind patients, staff, and the wider public of the importance of staying hydrated to reduce the risk of developing a urinary tract infection. The campaign which includes posters and leaflets will also specifically target care homes across the Scottish Borders.

7.0 Cleaning and the Healthcare Environment

7.1 Health Facilities Scotland (HFS) publishes quarterly reports on cleanliness standards and estates fabric across NHS Scotland. The most recently published report covers the period January to March 2024. Figure 11 below shows the cleanliness score for NHS Borders January-March 2024 was 95.4%. In the same period, the estates score was 98.4%.

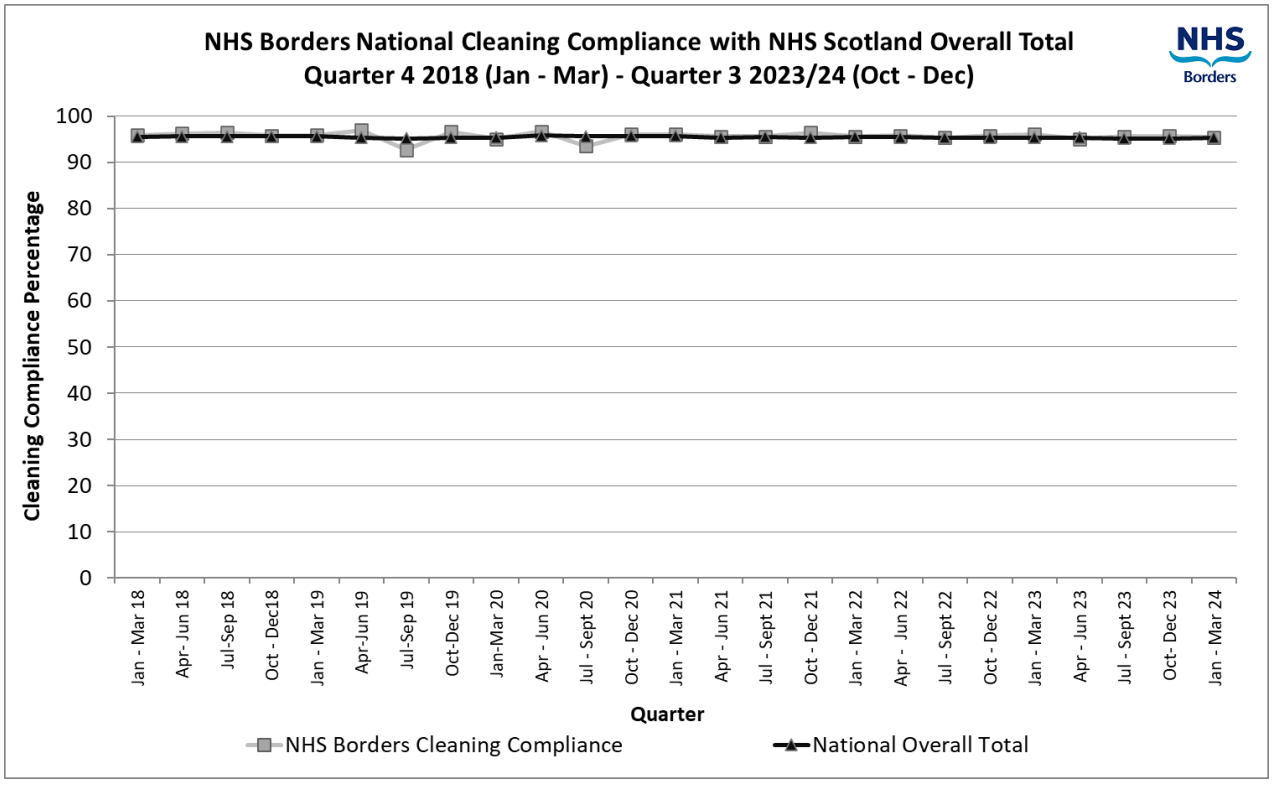


Figure 11: NHS Borders cleaning compliance against the NHS Scotland average by quarter

8.0 Hand Hygiene

8.1 The Infection Prevention and Control Team has recently undertaken further hand hygiene audits across NHS Borders. The outcome of these audits will be included in the next update to the Board.

8.2 Changeover to alternative hand hygiene products across NHS Borders is progressing following the announcement that our previous supplier has gone into administration. The changeover across community sites is almost complete after which BGH will be converted to the new product range (soap, alcohol gel and skin care products). The process is being coordinated by a short life working group to ensure no area is left without hand sanitising products and to run-down existing product to minimise waste.

9.0 Infection Control Work Plan 2024/25

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 Significant Infection Prevention and Control resource has been diverted to support the work of the COVID-19 Deaths Investigation Team (CDIT). This is a specialist unit within the Crown Office & Procurator Fiscal Service (COPFS) tasked with investigating the deaths of care home residents and workers related to COVID-19.

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

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

	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	2	1	4	4	1	2	4	2	5	1	5
Total SABS	2	1	4	4	1	2	4	2	5	1	5

Clostridioides difficile infection monthly case numbers

	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
Ages 15-64	1	1	0	0	2	0	0	0	0	0	1
Ages 65 plus	1	2	2	0	2	0	1	1	2	1	1
Ages 15 plus	2	3	0	0	4	0	1	1	2	1	2

Cleaning Compliance (%)

	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024
Board Total	95.5	96.7	95.9	95.5	95.9	96.18	96.42	95.14	96.1	95.2	95.9

Estates Monitoring Compliance (%)

	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024
Board Total	97.5	98.3	97.5	98.0	98.09	98.62	97.86	95.37	98.61	98.7	98.5

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	0	1	1	0	1	2	0	1	0	2
Total SABS	1	0	1	1	0	1	2	0	1	0	2

Clostridioides difficile infection monthly case numbers

	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
Ages 15-64	0	0	0	0	1	0	0	0	0	0	0
Ages 65 plus	1	0	0	0	0	0	0	1	2	1	0
Ages 15 plus	1	0	0	0	1	0	0	1	2	1	0

Cleaning Compliance (%)

	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024
BGH Total	98.3	99.0	98.1	98.4	99.0	98.1	98.4	98.0	98.3	95.2	95.1

Estates Monitoring Compliance (%)

	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024
BGH Total	98.3	99.0	98.1	98.4	98.4	98.0	98.3	99.0	98.1	98.7	98.3

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

	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
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

	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
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

	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	1	3	3	1	1	2	2	4	1	3
Total SABS	1	1	3	3	1	1	2	2	4	1	0

Clostridioides difficile infection monthly case numbers

	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
Ages 15-64	1	1	0	0	1	0	0	0	0	0	1
Ages 65 plus	0	2	2	0	2	0	0	0	0	0	1
Ages 15 plus	1	3	0	0	3	0	0	0	0	0	2

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 update as required by SGHD and has not been subject to any prior consultation or engagement although much of the data is included in the monthly infection control reports which are presented to divisional clinical governance groups and the Infection Control Committee.

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 NHS Borders Board

2.4 Recommendation

Committee members are asked to:

- **Discussion** – Examine and consider the implications of a matter.

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**

- **No Assurance**

3 List of appendices

Appendix A: Supplementary information and definitions
Appendix B: Outbreak summary

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

APPENDIX B

NHS Borders Clusters as at 20/06/2024 (CLOSED INCIDENTS ONLY)					
Outbreak start date	**Outbreak location(s)**	**Organism**	**Positive patient cases**	**Patient deaths** (COVID recorded on DC)	**Suspected/ confirmed staff cases**
02/05/2024	DME14, ward closed	COVID	22	0	0
03/05/2024	BSU, Bay 1	COVID	2	0	0
13/05/2024	WARD 4, Bay 4	COVID	5	0	0
27/05/2024	DME14, Bay 4	COVID	2	0	0
28/05/2024	Borders View, Bay 3	COVID	12	0	3

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 August 2024**
Title:	**Q4 Risk Management Report**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality and Improvement**
Report Author:	**Lettie Pringle, Risk Manager**

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):

- Effective

2 Report summary

2.1 Situation

The Risk Management Quarter 4 report is presented to the Health Board to provide a level of assurance that risk management processes and systems are in place and effective. This report outlines risk management progress throughout 2023/24 with recommendations made to enhance these throughout 2024/25.

2.2 Background

To be fully effective, risk management should be part of the organisational culture. It should be embedded into the organisation's philosophy, practices and business processes, rather than be viewed or practiced as a separate activity. When this is achieved, everyone in the organisation is involved in the management of risk. Risk management is a responsibility of NHS Borders and all staff to work in partnership to achieve best practice. The Risk Management Strategy, Policy and processes establish a core framework which supports the achievement of objectives for NHS Borders.

2.3 Assessment

Achieving both strategy and policy objectives have seen an improvement in quarter 4 with three objectives moving from an amber RAG status to green, 2 strategy objectives and one policy objective. Strategy objectives have been largely fulfilled although ongoing actions will be required to ensure this remains. Two policy objectives remain as an amber RAG status relating to involvement of stakeholders and risk owners using the risk management framework consistently. Whilst the framework and supporting processes are in place, there is still some inconsistency with documenting risks on the organisational risk management system.

To support achieving strategy and policy objectives work has been underway during 23/24 to break down silos across specialties and ensure risk management is built into functions as business as usual. Whilst this is not yet fully mature, a number of processes and links to subjects have been made to move into a predictive, proactive and reactive risk model.

Quarter 4 saw significant improvement in adhering to the 104-day timescales for risk approval. The chart on page 16 of the report shows the improving trend to achieving the target level.

There are a number of consistent themes identified in the gaps in controls these relate to staffing, training, finance, premises and equipment.

Risk Management Key Performance Indicators have not been fully met as at the end of quarter 4. Further actions have been put in place by clinical boards and corporate services to ensure these are met in 24/25.

There are a number of standing recommendations that are in place for all quarterly reports, these remain in quarter 4. New recommendations have also been made to support operational risk improvements:

i. Managers to note the Very High risks and contact their Risk Champion or the Risk Team for support when providing SBAR updates to Operational Planning Group if required.

ii. Managers who have received a Risk Quality Assessment Tool should prioritise undertaking actions identified to improve the quality of risk information on the risk register. The Risk Team is available for further support if required.

iii. Note the risk movement across the organisation, particular escalation of risk to a Very High risk level and de-escalation of Very High risks.

iv. Note the themes identified around gaps in risk control and consider whether gaps are appropriately addressed within risk action plans.

2.3.1 Quality/ Patient Care

Supports the risk management activities of the organisation to attain corporate objectives and ultimately the effective delivery of safe and effective healthcare.

2.3.2 Workforce

Supports the risk management activities of the organisation to attain corporate objectives and ultimately the effective delivery of safe and effective healthcare.

2.3.3 Financial

Supports the risk management activities of the organisation to attain corporate objectives and ultimately the effective delivery of safe and effective healthcare.

2.3.4 Risk Assessment/Management

To ensure that NHS Borders' corporate liabilities are managed to an effective standard reflecting good practice and robust governance, the current risk management framework follows the nationally recognised standard: BS ISO 31000 Risk Management and the Government issued Orange Book.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because it is not required for this report.

2.3.6 Climate Change

Supports the risk management activities of the organisation to attain the corporate objectives and ultimately the effective delivery of safe and effective healthcare

2.3.7 Other impacts

If intelligent, informed decisions are being made and the correct level of risk being taken, then there is a much higher likelihood of achieving the objectives and strategies of NHS Borders.

2.3.8 Communication, involvement, engagement and consultation

The Committee has carried out its duties to involve and engage external stakeholders where appropriate.

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, 6 May 2024
- Audit and Risk Committee, 20 May 2024

2.4 Recommendation

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

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

2 List of appendices

The following appendices are included with this report:

- Appendix 1, Risk Management Quarter 4 Report

NHS Borders

Risk Management Quarterly Report

January 2024 – April 2024

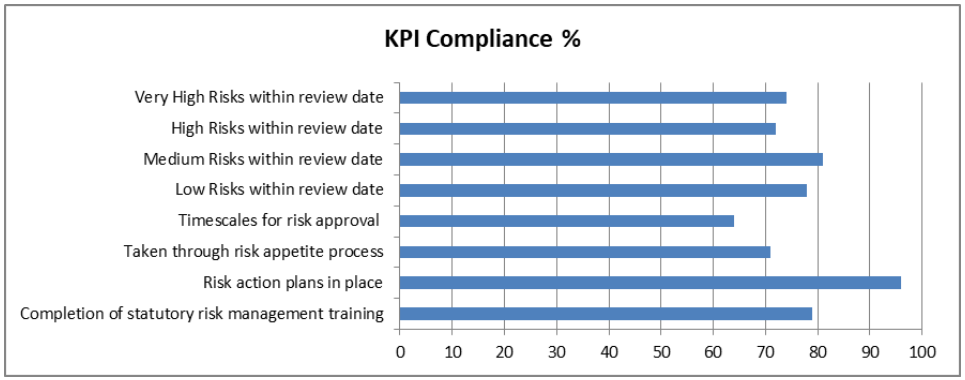
Ruth Macdonald
15/04/2024

Contents

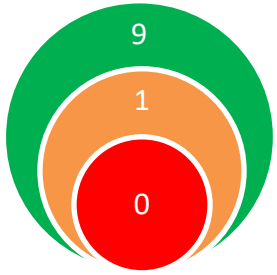
Table of Charts

Dashboard Overview of Risk Management Quarterly Report

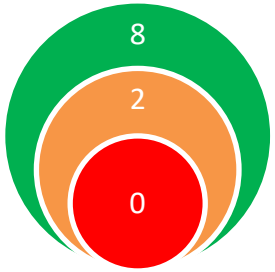
As at 04.04.2024.

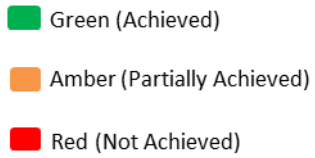


Strategy Objectives RAG Status

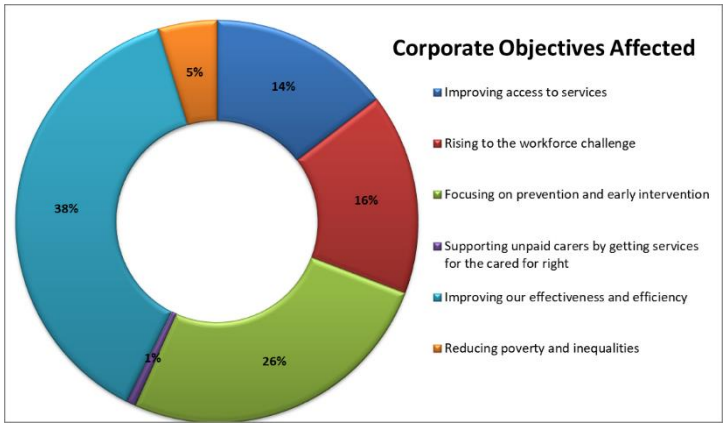


Policy Objectives RAG Status





Risk Status



Comparison showing movement of risk

Q3 2023/24					Q4 2023/24				
1	1	7	14	5	1	2↑	6↓	14	4↓
3	32	35	40	12	3	27↓	35	41↑	9↓
26	63	245	54	23	26	64↑	250↑	54	25↑
37	78	103	76	14	38↑	80↑	90↓	71↓	15↑
11	14	15	9	25	11	15↑	15	13↑	23↓

Risk Appetite Overview

	Outwith	Within	Not Specified	Total
Acute	12	305	0	**317**
Allied Health Professionals	3	65	0	**68**
Learning Disabilities	1	9	0	**10**
Mental Health	3	126	0	**129**
Primary & Community Services	3	188	0	**191**
Support Services	6	211	0	**217**
	28	**904**	**0**	**932**

	Acute	Allied Health Professionals	Learning Disabilities	Mental Health	Primary & Community Services	Support Services	Total
Treat	203	30	5	49	99	105	**491**
Terminate	13	0	0	2	9	4	**28**
Tolerate	98	38	5	78	83	105	**407**
Transfer	3	0	0	0	0	3	**6**
Total	**317**	**68**	**10**	**129**	**191**	**217**	**932**

1. Introduction

i. Healthcare is a complex system and has increasing pressures relating to infrastructure, workforce and finance with significant areas of risk resulting from the context in which healthcare operates. Risks to patients, risks to staff, risks to the public and risks to the corporate healthcare organisation established as the infrastructure within which healthcare is provided. On this basis, healthcare risk management is not about 'clinical' versus 'non-clinical' risk. It is about a holistic, enterprise-wide approach to risk identification and management. It is about engaging everyone in the process, from front-line staff up to the Board. Successfully managing risk is, therefore, a key imperative for the healthcare professional, manager and board member.

ii. Risk Management is not about managing a list of risks, it is about:
- Setting the right objectives
- Selecting the best strategies for achieving them
- Running the operational day-to-day activities and making the right decisions to achieve the objectives
- Doing the above intelligently, with the help of the right people and based on the best information available

iii. In other words, good risk management is good management. If intelligent, informed decisions are being made and the correct level of risk being taken, then there is a much higher likelihood of achieving the objectives and strategies of NHS Borders.

iv. The data included within this report was extracted from the electronic risk management system on 4th April 2024.

2. Risk Management Strategy

i. The Risk Management Strategy lays out the principal organisational strategies towards implementing effective risk management; this was approved by the board in April 2021.

ii. The Strategy contains ten objectives reflecting the risk management targets of the organisation.

Chart 1: NHS Borders Strategy Objectives (measured by RAG status issued within organisational scorecards)

Strategy Objective	Q1	Q2	Q3	Q4	Comments
NHS Borders risk management will follow international standard BSI 31000	Green	Green	Green	Green	Risk management process follows BSI31000, ensuring that the organisation is aware of any updates to this standard and associated guidance documents. Following the implementation of the Blueprint for Good Governance, the Orange Book is integrated into the process.
A single system approach for all types of risk	Green	Green	Green	Green	There is a single risk management process in place for all risks in NHS Borders.

Move from a reactive to proactive risk management stance	Amber	Amber	Amber	Green	Risks articulated on the risk management system are increasingly reflective of risks being faced. A piece of work has been undertaken to ensure risks in development are approved onto the risk register where appropriate, and those that are out of date are re-assessed. This has proved effective in increasing performance around these areas. Due to capacity within the Health and Safety team there is a delay in risk owners receiving advice around OH&S risks and whether they can be amalgamated or removed from the risk register. Work is ongoing to support the H&S Team.
All risk management processes are electronic; adverse events, risk register, risk assessment, claims and complaints	Green	Green	Green	Green	All risk management processes are held within the Datix system. National framework agreement now in place, NHS Borders due to move to InPhase system 24/25.
An education program is in place to support staff to implement risk management	Green	Green	Green	Green	A training programme was implemented in 2021/22 and is refreshed yearly to identify gaps and provide adequate and equal support to all staff. Supporting digital stories and how to videos have been created to enhance training and knowledge of risk management. Continual development of Risk Management Awareness Sessions has strengthened this programme.
Support achievement of the Clinical Strategy, local health plans and health and social care partnership	Green	Green	Green	Green	Work has been undertaken to ensure closer working with the health and social care partnership, including the establishment of a risk integration group (Integrated Risk Forum). Meetings are embedded to ensure closer communication between the Risk Management functions of NHS Borders and SBC, led by the Chief Officer. Work has been carried out to ensure a risk-based approach is built into the NHS Borders Annual Delivery Plan and Financial Plan.
A risk appetite is in place that will reflect the organisation's position	Amber	Amber	Amber	Green	The risk appetite process was reviewed and approved by the Health Board in February 2024. This is fully embedded into OPG scrutiny.
Support a positive risk management culture	Amber	Green	Green	Green	Visibility of the risk management subject has increased and embedded within organisational processes. An increase in uptake of the risk management training program has increased understanding by management. There are still small pockets where improvement could be gained but a shift in understanding has increased a positive risk culture.

Leadership and commitment to risk management throughout the organisation will be reflected through board leadership	Green	Green	Green	Green	Commitment to risk management through board leadership continues to improve in Quarter 4; increased scrutiny of risks has allowed better understanding of the processes, procedures and systems in place. This approach has given more value to the strategic and operational risk registers. An annual cycle of development sessions with the Health Board further increases knowledge and understanding.
Risk management assurance will be gained through governance structures	Amber	Amber	Green	Green	Governance structures are becoming more robust and this work has continued throughout 2023/24. A recent internal audit of risk management governance received reasonable assurance with some minor improvements required. A piece of work has been undertaken to establish a Board Assurance Framework which will strengthen this structure further.

3. Risk Management Policy

i. This policy explains how NHS Borders intends to deliver its risk management strategy by embedding processes and structures for risk into normal management practices.

ii. These management practices ensure that risks are managed appropriately in line with statutory, mandatory and best/good practice requirements. The policy lays out how this will be achieved using a comprehensive and cohesive risk management framework underpinned by clear accountability.

iii. The policy contains ten objectives reflecting the core business of the organisation: the delivery of person centred, safe and effective healthcare.

Chart 2: NHS Borders Policy Objectives (measured by RAG status issues within organisational scorecards)

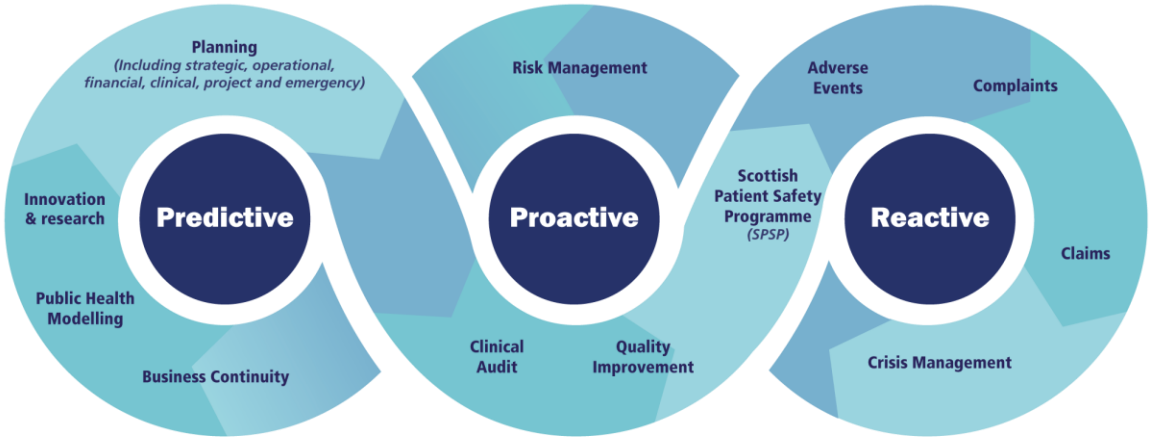
Policy Objective	Q1	Q2	Q3	Q4	Comments
Inclusion of appropriate stakeholders in the risk management process	Amber	Amber	Amber	Amber	40% of finally approved risks had no documented stakeholder involvement. This is a 2% improvement in comparison to Q3 of 2023/24.
Risk management training is available to the organisation to support a positive risk management culture	Green	Green	Green	Green	Development and implementation of the new Risk Management Training plan was undertaken in Q1 of 2023/24; this has been further developed with the creation of additional digital stories, eLearning and bespoke training throughout the year. Promotion of risk management training videos continues with positive feedback received highlighting these as helpful tools.

Key risks must be identified	Green	Green	Green	Green	The risk profile of the organisation has remained the same from 2022/23 into 2023/24, with the majority of risks being identified as medium and high risks; this reflects the increasing risks being faced by NHS Borders as the number of very high and high risks steadily rise, whilst medium risks remain relatively consistent, suggesting both mitigation and escalation of risk. Risk movement within the profile shows the identification of risks continues to improve as the organisation becomes more risk aware.
Proactive risk assessment must be used to minimise occurrences of adverse events	Amber	Amber	Amber	Green	This agreed risk management Key Performance Indicator (KPI) for all risks to have action plans to minimise liabilities has a compliance level of 96%; Local Risk Management Improvement Plans, supported by the Risk Champion Network in Clinical Boards, are fed into the OPG on a quarterly basis to provide assurance that risk management responsibilities are highlighted and improved upon.
Risk management performance of very high risks will be monitored through organisational performance review arrangements	Green	Green	Green	Green	Clinical Board performance reviews were suspended in 2020/21 and 2021/22 due to COVID-19 priorities but restarted in 2022/23.Risk management information was fed into these in Q4.
Establish the development of a learning culture	Green	Green	Green	Green	Mental Health and Primary & Community Services Clinical Boards and Support Services each publish an adverse event update to keep staff informed. Acute Services are currently implementing this in their Clinical Board. Training videos have also been developed by the Risk Team covering both risk management and adverse events. An annual training programme is in place for staff across the organisation.
The risk management framework and supporting processes are consistently used by risk owners.	Amber	Amber	Amber	Amber	Implementation of training videos and eLearning on various aspects of the risk management process have improved understanding and completion of risk management responsibilities, as well as allowing bespoke sessions and additional support to be offered by the Risk Team. The implementation of the Risk Champion Network has also enhanced organisational awareness and understanding of risk management. Whilst the framework and supporting processes are in place, there is still some inconsistency with documenting risks on organisational risk management systems.
Risks are escalated in accordance with the policy arrangements within the Risk Management Policy.	Green	Green	Green	Green	Escalation of risks to the Clinical Board meetings/Operational Planning Group continues as appropriate.

The effective use of information management and technology to support the management of risk.	Green	Green	Green	Green	National work has started on standardising adverse event types across NHS Scotland led by Health Improvement Scotland. The Risk Management system used in NHS Borders is reviewed regularly to ensure it continues to record required information. The Types of Adverse Event list is updated annually with involvement from key stakeholders to more accurately capture the types of event faced by NHS Borders.
NHS Borders complies with national standards and guidance relating to risk management published by Healthcare Improvement Scotland.	Green	Green	Green	Green	System and policy in compliance with HIS standards, BSI 31000 Risk Management Standards and the Orange Book.

4. Predictive, Proactive, Reactive workstreams

To support the strategy and policy objectives work has been underway throughout 23/24 to break down silos across the predictive, proactive and reactive workstreams as outlined below:



Progress made to work towards this model in 23/24 in NHS Borders:

- Risk management has been built into planning functions (ADP, financial plans, emergency planning etc).
- A process for project risks which are captured through research and innovation is now in place where very high risks identified within a project that could impact on the organisation are entered into our operational risk register as well as any residual risk following the completion of a project.
- Risk identification is undertaken through intelligence sharing meetings with Clinical Effectiveness highlighting quantitative information to inform any gaps or areas of uncertainty.
- A monthly meeting with the Resilience Team and Risk Team to highlight any emerging risks, risks identified through national regional and local exercises and debriefings.

- The link between risk management and adverse events has always been there but this is now being strengthened further through the review of the national Adverse Event Framework.
- Additionally, a national piece of work to update the risk matrix used across NHS in Scotland is currently being undertaken and will support consistency across all areas in measuring risk in today's landscape.

5. Risk Management Framework

i. To ensure that NHS Borders' corporate liabilities are managed to an effective standard reflecting good practice and robust governance, the current risk management framework follows the Orange Book, supported by the nationally recognised standard, BS ISO 31000 Risk Management.

ii. Chart 3 outlines how NHS Borders integrates the risk management framework into its activities:
- **Governance and Leadership** outlines how management demonstrates leadership and commitment.
- **Integration** outlines how risk is integrated into the organisational structures and context.
- **Collaboration** highlights how the organisation articulates its risk management commitment, roles and responsibilities, resources and communication.
- **Implementation** outlines how the framework is being implemented within NHS Borders.
- **Evaluation** is how NHS Borders measure the effectiveness of the risk management framework.
- **Continual Improvement** highlights how NHS Borders adapts and strives towards continual improvement.

Chart 3: British Standards Institute Risk Management Framework

6. Very High Operational Risks

i. There are 27 Very High risks within the operational risk register. Out of these risks, 26 indicate that they do not have an adequate level of control in place.

ii. Of the 27 Very High risks:

- One risk has been taken through the risk appetite process and escalated to BET for decision; agreement to tolerate has been given until a service review is undertaken. The risk also incorrectly indicates that there is an adequate level of control in place (4502).
- Four risks cite training as a gap in the controls (4391, 4728, 4676 and 949).
- Sixteen risks have listed staffing shortages, including a lack of existing capacity/supporting roles, as a control gap (1297, 4502, 4397, 4676, 4554, 4391, 4624, 4723, 4728, 4693, 1434, 1147, 4686, 398, 1848 and 949).
- Eleven risks cite funding as a gap in controls (4198, 4557, 4676, 4391, 4658, 4723, 4502, 4728, 4746, 4725 and 4686).
- One risk is fluctuating due to occupancy within the Mental Health in-patient wards and lack of alternative arrangements (4430).
- A decant area is required to carry out remedial works for one risk relating flooring across the system (4582).
- Four risks have indicated that inappropriate environments are a barrier to reducing risk (835, 4397, 4491 and 4492).
- One risk relating to the closure of the Children's Therapy Unit (4114) is being tolerated by OPG whilst work commences to terminate the risk.

iii. Additional information on Very High operational risks can be found in Appendix 2. The Operational Planning Group (OPG) Risk Timetable outlines the outcomes of risk discussion and highlights future dates that risk items are required.

7. Risk Register Summary/Analysis

7.1 Risk Profile

i. Currently there are 932 risks within the operational risk profile.

Q3 2023/24

1	1	7	14	5
3	32	35	40	12
26	63	245	54	23
37	78	103	76	14
11	14	15	9	25

Q4 2023/24

1	2↑	6↓	14	4↓
3	27↓	35	41↑	9↓
26	64↑	250↑	54	25↑
38↑	80↑	90↓	71↓	15↑
11	15↑	15	13↑	23↓

The above profiles do not include risks in development

ii. The majority of risks identified are graded as Medium or High risk, which is reflective of last year's figures.

iii. A small decrease in Very High risks has been noted in Quarter 4, suggesting that these risks are being mitigated appropriately through the organisational risk appetite process.

iv. Nine Very High risks have been fed into the Operational Planning Group in Quarter 4 by Risk Owners or General Managers/ Service Leads; a breakdown of all Very High risks out with risk appetite is included as Appendix 2 and outlines the outcome agreed by the Operational Planning Group.

7.1.1 Numbers of Risks Recorded by Risk Types

i. The below chart (Chart 4) covers risks within the operational risk register to provide an overview of the most prevalent types of risk within NHS Borders. This does not include risks recorded on the strategic risk register or within project risk and issues logs.

ii. As NHS Borders follows an Enterprise Risk Management approach, the risk register allows for more than one type of risk to be entered per risk assessment on the system; inevitably, there are a higher number of types of risk than actual risk assessments.

Chart 4: Types of Risk

Risk Grouping	Type of Risk	Total Q1 23/24	Total Q2 23/24	Total Q3 23/24	Total Q4 23/24	% Total Q1 23/24	% Total Q2 23/24	% Total Q3 23/24	% Total Q4 23/24	Increase/ Decrease from last Q
Clinical Risk	Healthcare Acquired Infection (HAI)	105	**100**	**101**	**84**	23.5%	**23%**	**24%**	**24%**	↔
Clinical Risk	Inequalities	66	**66**	**76**	**77**					
Clinical Risk	Patient safety/ clinical risk/ clinical activity	435	**457**	**472**	**497**					
Corporate Risk	Adverse publicity/ reputation	345	**353**	**364**	**366**	40%	**40%**	**39%**	**39%**	↔
Corporate Risk	Business continuity	200	**205**	**207**	**198**					
Corporate Risk	Staffing and competence	209	**213**	**205**	**221**					
Corporate Risk	Information governance	39	**42**	**43**	**44**					
Corporate Risk	Legal	139	**148**	**148**	**157**					
Corporate Risk	Political	45	**45**	**42**	**47**					
Corporate Risk	Technological	53	**54**	**60**	**59**					
Financial Risk	Financial/ economical (including damages and fraud)	195	**205**	**211**	**209**	7.5%	**8%**	**8%**	**8%**	↔
Health & Safety Risk	OH&S Activity	137	**143**	**148**	**150**	28.5%	**28.5%**	**28.5%**	**28.5%**	↔
Health & Safety Risk	OH&S Environment and Equipment	333	**340**	**352**	**358**					
Health & Safety Risk	OH&S Specific - Ligature	22	**23**	**24**	**26**					
Health & Safety Risk	OH&S policy - generic	36	**38**	**35**	**34**					
Health & Safety Risk	OH&S Specific - Aggression and Violence	115	**116**	**117**	**120**					
Health & Safety Risk	OH&S Specific - Moving and Handling	95	**96**	**100**	**106**					
Project Risk	Project	14	**15**	**17**	**15**	0.5%	**0.5%**	**0.5%**	**0.5%**	↔

iii. Within the occupational health & safety risk type, the option for 'OH&S Policy – Generic' has been removed at the request of the Health & Safety Topic Specialists. Risks which still have this type selected will be checked by the Risk Team and updated appropriately.

iv. The number of risks within the clinical, corporate and health & safety risk types have increased in Quarter 4, albeit minimally. Clinical risks have continued to increase throughout the rolling year but not significantly. The occupational health & safety risk type has also seen a small increase in numbers of risks throughout the rolling year; this could be attributed to the on-going identification and updating of operational risks to ensure health & safety risk assessments are captured, as per feedback from the Health & Safety Risk Management Internal Audit.

v. Although there has been an increase in the number of risks for some of the overarching risk types, the overall percentages of risk categories remain fairly consistent with relatively small fluctuations in most types of risk throughout the year.

vi. The highest reported risk is corporate risk followed by occupational health and safety risk, which is a continuing theme since the implementation of the electronic risk register in 2014. This may be due to the active participation of Topic Specialists covering these risk types. Work has been undertaken to train additional Topic Specialists to support Risk Owners to identify gaps in their risk registers and provide risk management advice relevant to their specialist area(s). This has been completed for Patient Safety, Pharmacy, Resuscitation, Resilience, Estates, Cyber Security, Information Governance, IT Projects and Infection Control. Work continues into Quarter 4 to provide risk training for Topic Specialists in IT Services.

vii. Health and safety risks are to be monitored by the Occupational Health & Safety Forum to ensure each risk register has OH&S risk represented.

viii. The Environmental Oversight Risk Group monitor risks relating to NHS Borders premises and maintain an overview of the environmental risk priorities across NHS Borders, and link into the healthcare governance processes. It will ensure that environmental risk issues are managed and escalated appropriately.

7.1.2 Risk Status

i. 53% risks on the register are being treated, 44% are being tolerated, 3% are to be terminated and <1% of risks are to be transferred. The organisation's tolerance level allows Risk Owners to tolerate High, Medium and Low risks using their own discretion; however, Very High risks can only be tolerated after consideration of the organisational risk appetite process and with agreement from the Operational Planning Group.

Chart 5: Risk Status

	Acute	Allied Health Professionals	Learning Disabilities	Mental Health	Primary and Community	Support Services	Total
Treat	203	30	5	49	99	105	**491**
Terminate	13	0	0	2	9	4	**28**
Tolerated	98	38	5	78	83	105	**407**
Transfer	3	0	0	0	0	3	**6**
Total	**317**	**68**	**10**	**129**	**191**	**217**	**932**

ii. In the chart above, it is important to note that Acute, Primary & Community Services and Support Services are putting resources into as many or more risks than they are tolerating. This may not be reflective of what is happening in reality.

iii. There are a number of risks inappropriately classified as terminate or transfer; some of these risks require input from the Risk Owner to update.

7.1.3 Risks Affecting Corporate Objectives

i. Risk Owners indicate on the register which risks could adversely impact on the achievement of the organisations corporate objectives. This allows for the accurate focus of resources when deciding on risk mitigation, which should be balanced against the overall risk profile that shows nearly three quarters of all risk is graded Medium.

ii. The Scottish Borders Health & Social Care Partnership released their Strategic Framework for 2023-2026 earlier this year. This framework outlines the new objectives which have now been implemented within NHS Borders, with regards to risk management. To ensure accurate quality of data being entered into the system, an exercise was carried out by the Risk Team in Quarter 4 so that risks are reflective of these new objectives. The 3 older corporate objectives have been removed from use.

iii. In the chart below (Chart 6), the number of risks affecting each corporate objective has been highlighted. This will not total the number of risks on the risk register as more than one corporate objective can be selected per risk.

Chart 6: Risks affecting Corporate Objectives

	Promote excellence in organisational behaviour and always act with pride, humility and kindness	Provide high quality, person centred services that are safe, effective, sustainable and affordable	Reduce health inequalities and improve the health of our local population	Improving access to services	Rising to the workforce challenge	Focusing on prevention and early intervention	Supporting unpaid carers by getting services for the cared for right	Improving our effectiveness and efficiency	Reducing poverty and inequalities
Q1	181	839	180						
Q2	169	805	171	24	8	15	2	32	3
Q3	165	801	171	37	17	38	2	54	11
Q4	**0**	**0**	**0**	**326**	**362**	**577**	**17**	**846**	**105**

7.1.4 Risk Appetite

i. There are currently 28 risks marked as out with organisational risk appetite; 20 of these risks have been or are actively being taken through the risk appetite process within Q1-Q4. In Quarter 4, 8 of these risks were given agreement to tolerate from the Operational Planning Group and 2 were escalated to the Board Executive Team for decision. 7 risks have yet to be taken through the process and 1 High risk has been marked outwith risk appetite in anticipation of the escalating risk level; this has been reflected within the target risk level by the Risk Owner and has previously been escalated to the Board Executive Team for decision. A conversation with the Risk Owner is required to ensure the risk level and risk appetite decision are accurate for this High risk.

Chart 7: Risk Appetite Overview

	Outwith	Within	Total
Acute	12	305	**317**
Allied Health Professionals	3	65	**68**
Learning Disabilities	1	9	**10**
Mental Health	3	126	**129**
Primary & Community Services	3	188	**191**
Support Services	6	211	**217**
	28	**904**	**932**

ii. A programme is continuously being undertaken to quality check all risks marked out with risk appetite; this will continue to improve accuracy of reports being fed into the organisation.

iii. The new Risk Appetite Policy, created in consultation with key stakeholders following a review of the Risk Management Policy, was approved for use by the Operational Planning Group, Board Executive

Team, Audit & Risk Committee and Health Board in Quarter 4; this will be implemented throughout the organisation as at 1st April 2024.

7.2 Risks in Development

i. There are currently 39 risks in development.

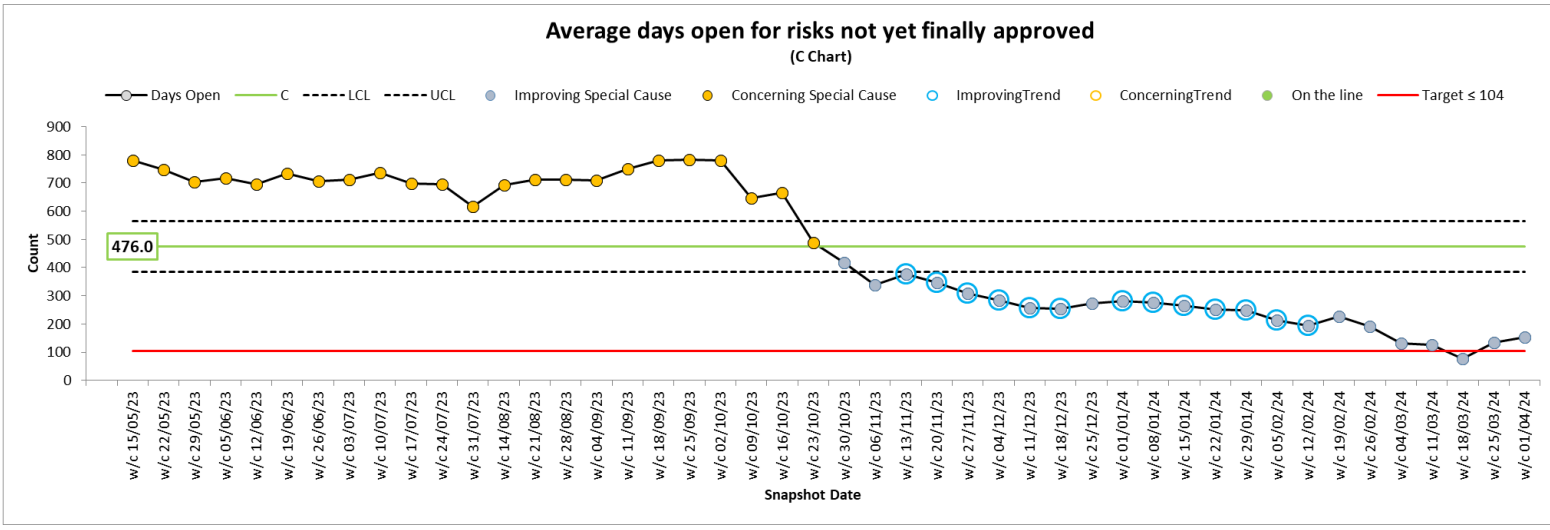
Chart 8: Risks in Development

	Learning Disability Service	Mental Health	Acute	Primary & Community Services	Allied Health Professionals	Corporate Services	**Total**
Very High	0	0	2	1	0	3	**6**
High	0	0	8	7	0	6	**21**
Medium	0	0	2	4	1	5	**12**
Low	0	0	0	0	0	0	**0**
Total	**0**	**0**	**12**	**12**	**1**	**14**	**39**

ii. Risk Owners should be reviewing their risks, including risks in development, within the agreed timescales as per the Risk Management Policy. Quarter 1 to Quarter 4 of 2023-24 has seen a 54% decrease in numbers of risks in development. This can be attributed to the removal of historic risks in development, such as those which are no longer relevant or that have been in development for a significant length of time, as indicated by Risk Owners. Risk Champions continue to encourage staff to move risks through the approval process so they become visible to the organisation, via the Risk Management Improvement Plans. It should be noted that approval is not always achieved within a timely manner, as only 45% of risks on the risk register being taken through this process within the 104 day timescale. However, out of the 39 risks in development, 64% can be approved within the 104-day timescale, which is a 42% improvement in comparison to Quarter 1.

iii. As part of the NHS Borders Safety Measurement and Monitoring Dashboard, timescales for approval are monitored. Average timescales for risks being left in development and not approved onto the risk register in Quarter 4 was 153 days. This requires improvement to meet the 104 day target; however, improving trends in Quarter 3 and Quarter 4 should be noted in Chart 9 (below). This is due to work which continues to support Risk Owners when reviewing and approving risks onto the risk register as appropriate, as well as removal of any risks which require re-assessment (no longer relevant/superseded).

Chart 9: Risks in Development (average days open)



7.3 Strategic Risk

i. The strategic risk register is continually reviewed by risk owners. This has been further supported by Quality Assessments on strategic risks to ensure they are following risk management process consistently and offering suggestions for improvement based on a compliance score.

Compliance Levels	Compliance %	Number of Strategic Risks
Excellent	80-100	4
Good	60-79.9	8
Fair	45-59.9	1
Weak	<45	0

ii. Reports from risk owners to deep dive into the strategic risks have been scheduled into work programmes of each committee. This is being evaluated to ensure this development is adding value to the governance structure.

Chart 10: Revised Strategic Risks 2023/24

Clinical Governance Committee *Laura Jones*	**Resource and Performance Committee** *Ralph Roberts*	**Public Governance Committee** *June Smyth*	**Staff Governance Committee** *Andy Carter*
(NEW) Whole System Flow Lynne Huckerby Status: On risk register	**Digital Infrastructure** June Smyth Status: On risk register	**Stakeholder Multi Agency Working** Ralph Roberts **Status: On risk register but requires review**	**Statutory/ Mandatory Training** Andy Carter Status: On risk register
(NEW) Quality and Care Assurance Laura Jones **Status: In Development**	**Climate Change** Andrew Bone Status: On risk register	**Public Involvement** June Smyth Status: On risk register	**Compliance with H&S Legislation** Andy Carter Status: On risk register
(NEW) Quality and Sustainability of Acute Services Lynne Huckerby **Status: In Development**	**Finance** Andrew Bone Status: On risk register	**Health Inequalities** Sohail Bhatti Status: On risk register	**(NEW) Workforce** Andy Carter **Status: Awaiting risk assessment**
(NEW) Quality and Sustainability of MH and LD Services Chris Myers **Status: In Development**	**(NEW) Medium Terms Plans** June Smyth **Status: In Development**	**(NEW) COVID Inquiry** Ralph Roberts Status: On risk register	**Industrial Action** Andy Carter Status: On risk register
(NEW) Quality and Sustainability of P&CS and Independent Contractors Chris Myers Status: On risk register	**(NEW) Organisational Resilience** June Smyth **Status: In Development**		
	Healthcare Environment Andrew Bone **Status: On risk register but requires review**		

7.4 Risk Movement

7.4.1 Risk Closures

i. Fifty-nine risks have been closed in Quarter 4 of 2023/24. The number of risks being removed from the system can be attributed to pockets of good practice by Risk Owners when reviewing their risks to ensure they are current, as well as successful mitigation and termination of certain risks facing their services. High numbers of merged/amalgamated and superseded risks can be attributed to work carried out by Risk Owners to review risk registers to ensure the content is manageable and accurate. High numbers of merged/amalgamated risks is due to extensive work carried out to amalgamate historic COVID-19 risk assessments with existing health and safety environmental risk assessments within Primary & Community Services. Successful mitigation of risks can be attributed to actions carried out by Risk Owners across the organisation to remove sources of risk, or introduce new controls to manage risk (only where appropriate and within resource constraints).

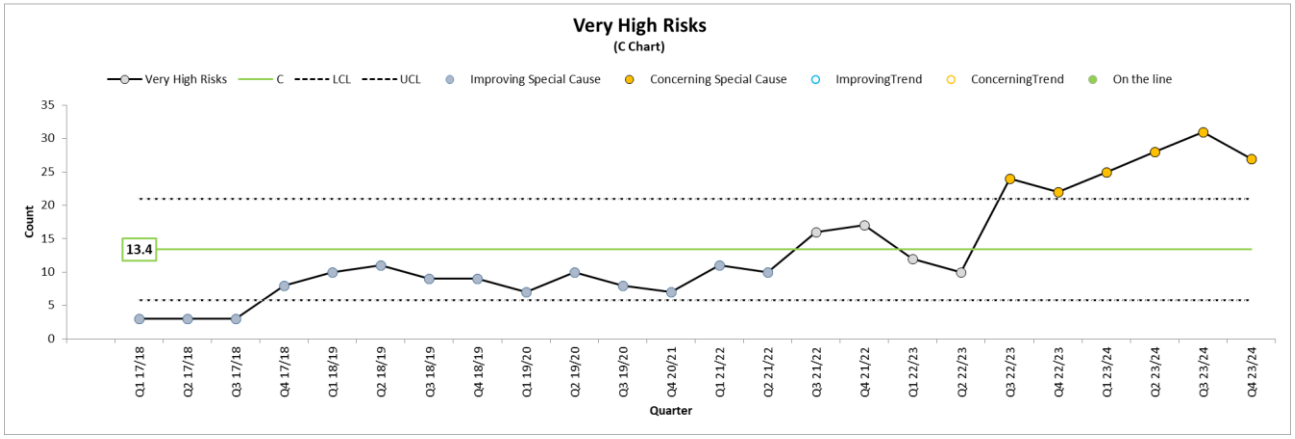
Chart 11: Risk Closures

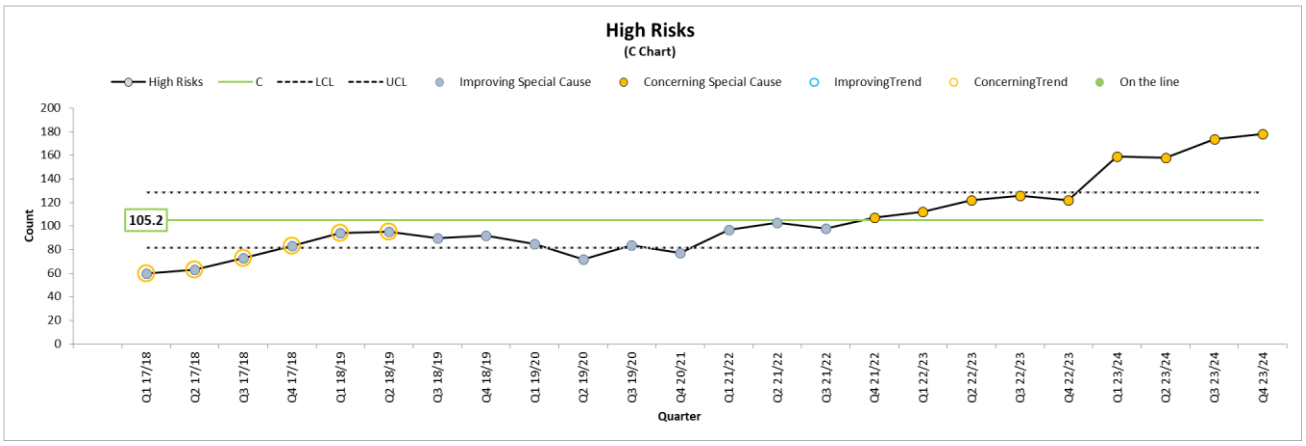
Closure Reason	No.
Duplicate	**6**
Entered in error	**1**
Merged/ Amalgamated	**18**
Mitigated	**13**
No longer relevant	**0**
Superseded	**10**
Terminated	**11**
	59

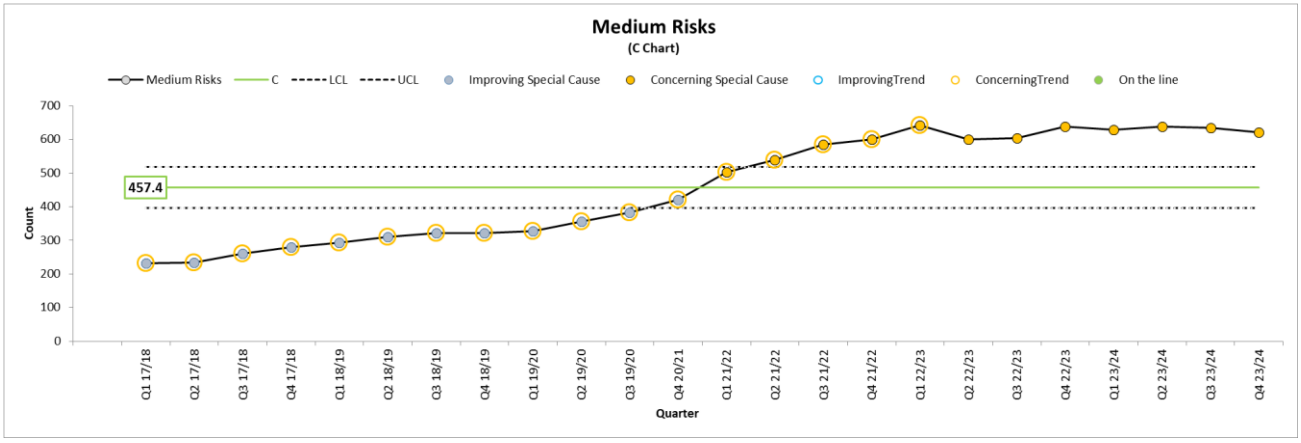
7.4.2 Risk Reduction/Increase

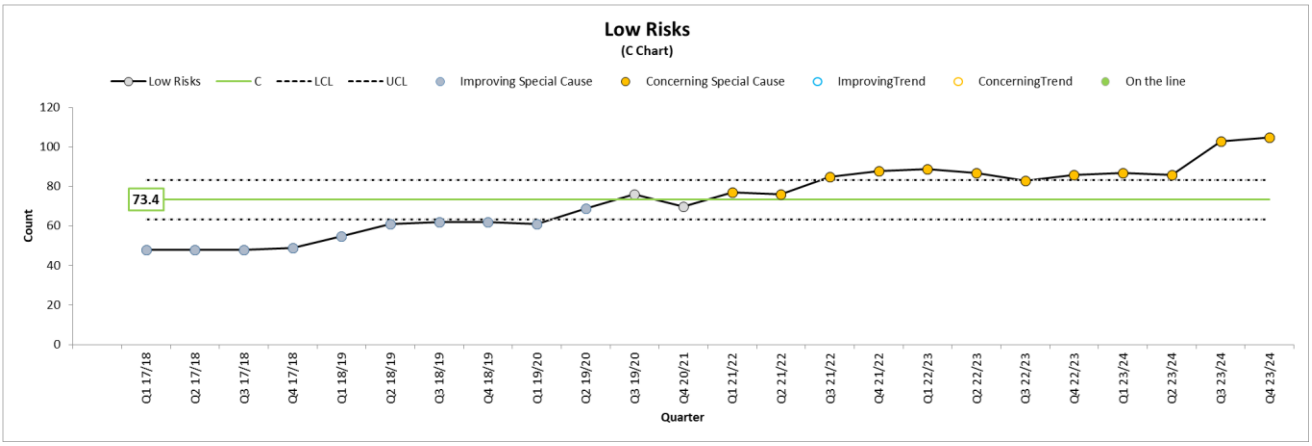
i. The total numbers of High and Low risks have increased in Quarter 4, whereas the number of Very High and Medium risks has reduced, albeit minimally.

Chart 12: Number of risks at each risk level









ii. It is important to note within these charts that an increase in numbers of risk could also highlight a positive change in the organisation's risk culture, meaning that more risk is being accurately identified and documentation updated appropriately.

iii. Although the levels of risk have changed slightly moving from Quarter 3 into Quarter 4 of 2023/24, it remains that 22% of all risk was graded as Very High or High.

iv. Two risks have been escalated to Very High risk within Quarter 4:

- 1848 – Operating Theatre Capacity; identified in August 2020 and escalated from High (15) to Very High (20) in January 2024.

- 1434 – Consultant Psychiatrist Vacancies; identified in December 2018 and escalated from Medium (9) to Very High (20) in March 2024.

v. Following the increased scrutiny of the risk appetite process and re-assessment of out-of-date risk assessments by Risk Owners, eleven risks have been reduced from Very High or have been removed entirely:

- 4559 (Haylodge House) – Taken through the risk appetite process and reduced to High (15) due to removal of staff from the premises; escalated to General Manager for decision on whether to close premises.

- 4574 (ED OOH reception staffing) – Not taken through the risk appetite process, risk reduced to High (16) as per feedback from a Risk Quality Assessment.

- 4720 (Working in CL3 Suite) – Taken through the risk appetite process and reduced to High (12) due to successful implementation of actions, including identification of a biological safety advisor and development of a code of practice.

- 4513 (Deregistration of Dental patients) – Taken through the risk appetite process, risk reduced to High (12) as per Risk Quality Assessment feedback and completion of mitigating actions.

- 4427 (Staffing in Community Hospitals) – Taken through the risk appetite process, risk reduced to High (16) due to successful implementation of mitigating actions.

- 4450 (Working in CL3 Suite) – Taken through the risk appetite process, removed from the risk management system as it has been superseded by risks 4720 and 4721.

- 4561 (Management of Water Safety) – Not taken through the risk appetite process, reduced to High (15) through completion of mitigating actions.

- 4684 (Clinical Chemistry service provision) - Taken through the risk appetite process, reduced to High (10) through completion of mitigating actions.

- 4721 (CL3 Suite Environment) - Taken through the risk appetite process and reduced to High (12) due to successful implementation of actions.

- 1460 (Management of Fire Safety) – Taken through the risk appetite process, reduced to High (15) through completion of remedial works to mitigate the risk.

- 850 (Registered Nurse staffing in Community Hospitals) – Taken through the risk appetite process, risk reduced to High (16) as per Risk Quality Assessment feedback and completion of mitigating actions.

7.4.3 New Risks

i. There were 56 new risks entered onto the operational risk register in Quarter 4, which shows continued good practice across the organisation in identifying risks and managing these through the system. Five of these risks indicate a Very High risk level.

- 4728 – Face Fitting Service Provision; identified in December 2023 and approved onto operational risk register in January 2024.

- 4746 – Medical Oncology Specialist Knowledge Gaps; identified in January 2024 and approved onto operational risk register in March 2024.

- 4693 – Systemic Anti-Cancer Therapy (SACT) Delivery; identified in October 2023 and approved onto operational risk register in March 2024.

- 398 – Patients receiving care in inappropriate settings; identified in January 2022 and moved from the strategic risk register to the operational risk register in January 2024.

- 835 – LD inpatient beds (previously taken through the risk appetite process); moved back to a risk in development for re-assessment and approved onto operational risk register again in January 2024.

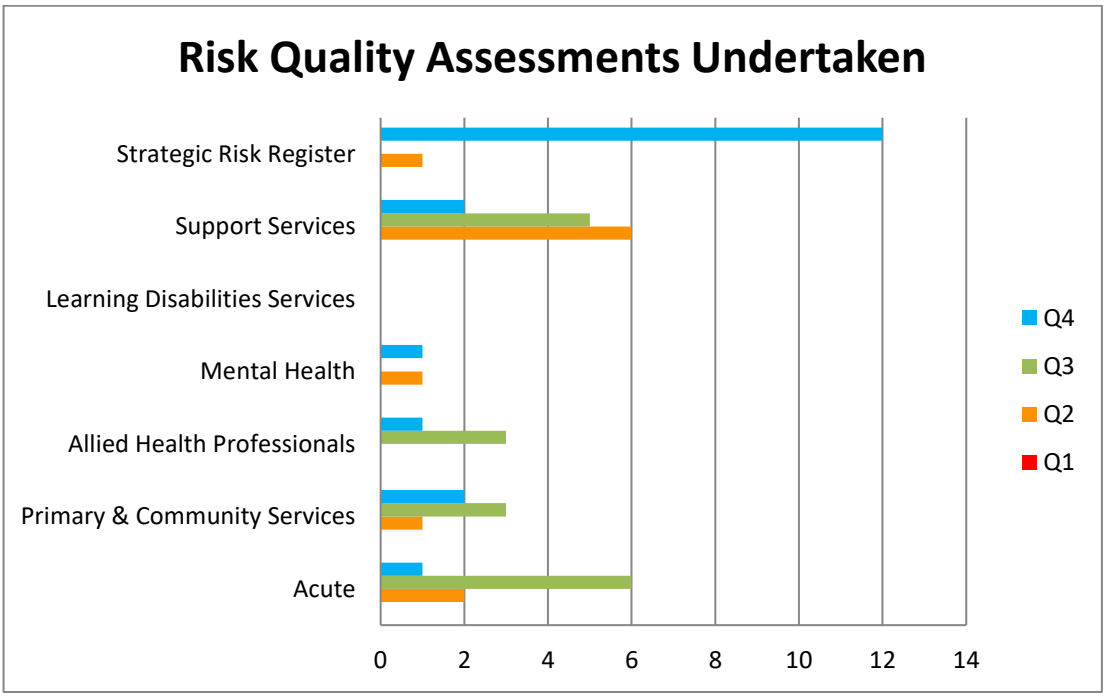
8. Risk Management Update

8.1 Themes

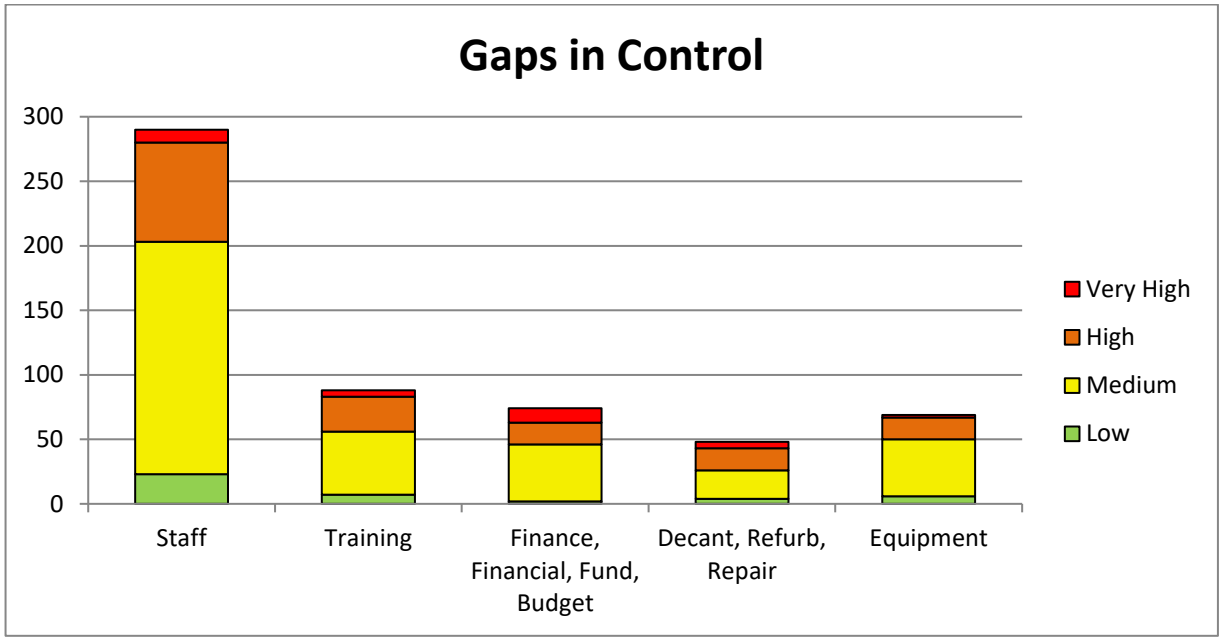
i. There is a continuing theme of risks being left unmonitored and out-of-date. This has been a consistent theme from 2020 to 2024, where relevant actions may be carried out but are not documented in the organisational system, and therefore are not fed through the governance structure of NHS Borders. To support improvements in this area, monthly reports are produced highlighting risks outwith review date and risks in development. These are sent to all General Managers and Directors for follow up with their teams.

ii. The compliance level for risks across the organisation being reviewed within the review date set by the Risk Owner is now over 70% for all risk levels; this is an improvement on last quarter and shows that compliance with this Key Performance Indicator is now being prioritised through the Risk Management Improvement Plans. When reviewing their risks, Risk Owners should be realistic about timescales for review to ensure they are documenting risks accurately, whilst adhering to the timescales in the Risk Management Policy. By setting unrealistic timescales for review, Risk Owners often fail to comply with this key performance indicator.

iii. Work is still underway to remove the 64 historic COVID-19 risk assessments from the operational risk register and amalgamate these with existing risk assessments where necessary. This has resulted in significant numbers of amalgamated, superseded and terminated risks being removed from the system. Risk Owners are supported by risk quality assessments by the Risk Team and opportunities to liaise via email and Microsoft Teams meetings to identify and discuss risks that are no longer required or could be merged. Please see further detail on risk quality assessments undertaken each quarter below:



iv. Staffing challenges has been identified as one of the biggest barriers to risk mitigation and is detailed as a gap within a large number of risk assessments; there are key areas where this poses a significant risk. Financial gaps have also been identified as preventing risk owners from mitigating their risks fully. Gaps in control and challenges when mitigating risk can also be seen for risks where a resolution is dependent on availability of decant facilitates and ward refurbishment works.



8.2 Risk Champions

i. The Risk Champion Network is now fully embedded within NHS Borders. Quarterly meetings are held between the 'Lead' Risk Champions of each Clinical Board/Corporate Services; the purpose of these meetings is to discuss any concerns, issues and themes arising across services, as well as Risk Management Improvement Plans and High Risk Assurance Reports.

ii. The success of the Risk Champion Network will be monitored by the Operational Planning Group.

8.2.1 Risk Management Improvement Plans

i. Risk Champions are asked to produce a Risk Management Improvement Plan for their Clinical Board/Corporate Services to be presented at quarterly meetings of the Operational Planning Group. This has progressed throughout 2023/24, with Learning Disabilities Service as an anomaly who will present two separate Risk Management Improvement Plans twice a year due to scheduling conflicts with the Governance meeting timetable.

8.2.2 High Risk Assurance

i. Clinical Boards/ Corporate Services will present a High Risk Assurance Report twice a year at Operational Planning Group. This piece of work will be overseen by the nominated Risk Champions. In Quarter 4;

- Administration, Management & Planned Care (Acute) gave full assurance to the Operational Planning Group that all High risks within the service are being managed appropriately and proportionately.

- Learning Disabilities were able to partially assure the Operational Planning Group that all High risks within the service are being managed appropriately and proportionately and requested escalation for one risk.

- The next High Risk Assurance Reports from Primary & Community Services, Unscheduled Care (Acute), Women's and Children's Services (Acute), Mental Health and Corporate Services are due to be presented to Clinical Board Governance Groups/Corporate Services Meeting and the Operational Planning Group in Quarter 1 and Quarter 2 of 2024-25.

ii. Risk 432 (access to LD inpatient beds) was raised by the LD Risk Champion via the High Risk Assurance Report as mitigation of the risk is outwith NHS Borders control. This risk will be scheduled for review by the Operational Planning Group in Quarter 1 of 2024-25.

iii. All High risks escalated by Clinical Boards and Risk Champions are under ongoing monitoring by the Operational Planning Group.

8.3 Risk Management Training

i. The Risk Team continue to support staff that are required to use the electronic risk management system and carry out their risk management roles and responsibilities, offering training in the form of face-to-face sessions, eLearning, digital stories, "How to" videos and sessions via Microsoft Teams. Sessions can also be arranged outwith the Risk Team's normal working hours, provided adequate notice is given and appropriate circumstances are arranged. Chart 13 shows the number of staff who have undertaken the listed training in that quarter.

ii. In Quarter 4, the Risk Appetite digital story was updated and re-released. Uptake for this digital story has been significantly higher than other digital stories in a short space of time. In Chart 13 below, numbers which are in italics and highlighted grey show views for a previous version of a digital story. As the views are reset when a video is replaced, the black font numbers in the white boxes below this show the number of views for the new digital story.

All training videos are available via the Risk Team microsite by visiting the Training tab, or can be accessed via the following link: Risk Management - YouTube

iii. Adverse Event Reporting eLearning saw little movement in numbers of staff completing, dropping to 3236 in Quarter 4 of 2023/24. The decrease in staff completing eLearning and the increase in total numbers of staff may have contributed to the drop below the 80% target for this Key Performance Indicator. Statutory and Mandatory training will be monitored through the Training, Education and Development (TED) Board with a governance line to Area Partnership Forum and Staff Governance Committee; this is part of the wider statutory and mandatory training compliance of NHS Borders.

Chart 13: Risk Management Training

	eLearning Courses						Bespoke Training											Digital Stories														
	Adverse Event Reporting	Adverse Event Approver	Final Approver for Adverse Events	Risk Register	Reports & Dashboards for Adverse Events	Reports & Dashboards for the Risk Register	Adverse Event Awareness Session	Adverse Event Approver	Adverse Event Topic Specialist	Practical Reports Session - Adverse Events	Practical Reports Session - Risk Register	Risk Register 1:1	Risk Register Topic Specialist	Risk Management Awareness Session (Risk Owners & Approvers)	Risk Management Awareness Session (All staff)	Bespoke Risk Workshop	Strategic Risk Register Overview (Deputies)	Strategic Risk Register 1:1	Introduction to Risk Management	Mini Risk Management Awareness Session	How to Facilitate Risk Conversations	Risk v Issue	Risk Matrix	Key Risks Checklist	Types of Risk	Developing SMART Action Plans	Risk Management Key Performance Indicators	Risk Appetite	The Role of the Risk Champion	Risk Management Improvement Plans	High Risk Assurance	Risk Governance
Q1	256	16	3	16	5	7		0	2	1	2	4		0	30	0	1	0	62	18	91		68		*32*	16	23	*90*	14	25	14	*47*
Q2	309	9	3	10	0	4		0	0	2	3	10	5	0	13	2	3	0	47	30	22		24		*20*	11	13	*19*	14	21	17	*12*
Q3	294	9	2	15	3	2		0	0	1	0	5	20	0	0	0	0	2	28	22	15	13	12	9	4	1	11	*19*	21	14	8	10
Q4	345	8	2	9	5	5	30	3	4	1	0	2	8	0	32	9	1	1	51	29	23	34	25	17	19	19	12	162	47	26	20	16

9. Risk Management System Update

i. The Risk Appetite Policy was approved in Quarter 4 and made available to the organisation. Guidance and training will also be updated and released to reflect changes in the process. This document can be found on the staff intranet by visiting the Risk Team microsite.

ii. The tendering process that NHS Borders has been involved in to procure a risk management system has now concluded with the tendering contracted being awarded to a company named InPhase. The contract has been finalised with National Services Scotland and InPhase, with the Buyers Guide issued in February 2024. A business case was presented to the Operational Planning Group and the Board Executive Team, who both gave approval to proceed with a call off contract. Work to build and implement this new system is expected to begin in Quarter 1 of 2024-25.

10. Risk Management Key Performance Indicators

i. The risk management key performance indicators were agreed by the Risk Management Board in June for 2021/22, and have been carried across into 2023/24 with agreement from the Operational Planning Group.

ii. To ensure consistent monitoring, the below table will guide the RAG status of the Key Performance Indicators.

Chart 14: Key Performance Indicators 2023-24

Compliance Status Indicator				
0-59.9%	60-69.9%	70.79.9%	80-99.9%	100%

Target Descriptor			Compliance Level: Target	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Status	Comments	
Within review date by risk level	**Current Risk Level**	**Review timescales (no more than)**								
	Very High	Every 6 months	90%	84%	50%	61%	**74%**		**Number of Risks Outwith Review Date = 7 of 27**	
	High	Every year		64%	58%	53%	**72%**		**Number of Risks Outwith Review Date = 50 of 178**	
	Medium	Every 2 years		52%	55%	57%	**81%**		**Number of Risks Outwith Review Date = 118 of 622**	
	Low	Every 2 years		51%	58%	65%	**78%**		**Number of Risks Outwith Review Date = 23 of 105**	
Timescales for risk approval	Risks in development	104 days	80%	22%	23%	63%	**64%**		**Number of Risks in Development unapproved and within 104-day timescale = 25 of 39**	
Risks taken through appropriate risk appetite process			100%	60%	64%	68%	**71%**		**20 of 28 risks outwith risk appetite have been taken through or are under review as per the risk appetite process**	
Action plans in place			100%	95%	95%	94%	**96%**		**41 of 932 risks on the risk register have no action plan in place**	
Number of staff completing risk management eLearning			80%	86%	82%	81%	**79%**		**eLearning**	**No of staff undertaken in Q4**
									Adverse Event Recording eLearning	**3236**

11. Recommendations

11.1 Standing Recommendations

i. Senior managers and Directors to continue to promote recording of adverse events and risk assessments on the appropriate form, supporting a move to a more positive, embedded and mature risk culture.

ii. Managers should ensure all their staff members have completed appropriate risk management relevant to their role, including statutory training and required refreshers.

iii. Agreed key performance indicators were not achieved in 2023/24; suggest no changes to KPIs in order to focus on fully attaining in the next financial year (2024-25).

iv. Risks in development require to be taken through the approval process in a more timely manner to achieve the 104 day target for approval as outlined in the Risk Management Policy.

v. Risk Owners should review their risks in compliance with their own allocated timescales, particularly High and Very High graded risks as these require review more frequently. Suggested timescales for review of risks can be found within the Risk Management Policy.

vi. Risks out with risk appetite must be fed into the Operational Planning Group as per the Risk Management Policy; all Risk Owners/Approvers should ensure they watch the updated Risk Appetite training video available on the Risk Team microsite.

vii. Note the high risks that have been escalated to Operational Planning Group for further organisational support.

viii. Consideration should be given to those risks which cannot be further mitigated with the action plans currently in place.

11.2 New Recommendations

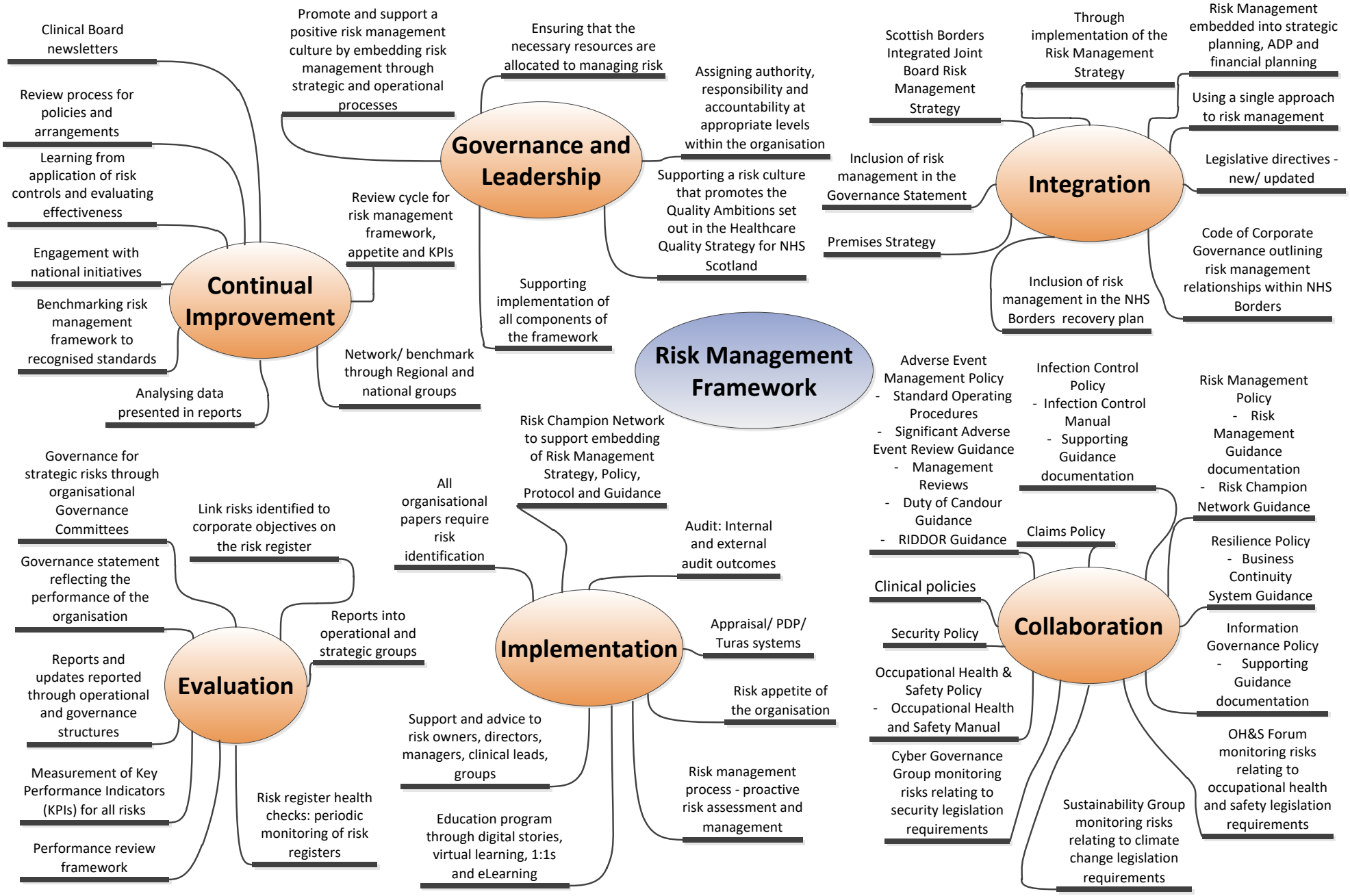
i. Managers to note the Very High risks and contact their Risk Champion or the Risk Team for support when providing SBAR updates to Operational Planning Group if required.

ii. Managers who have received a Risk Quality Assessment Tool should prioritise undertaking actions identified to improve the quality of risk information on the risk register. The Risk Team is available for further support if required.

iii. Note the risk movement across the organisation, particular escalation of risk to a Very High risk level and de-escalation of Very High risks.

iv. Note the themes identified around gaps in risk control and consider whether gaps are appropriately addressed within risk action plans.

Appendix 1 – NHS Borders Risk Management Framework



Appendix 2 – Operational Planning Group (OPG) Risk Timetable

Risk ID & Risk Owner	Clinical Board/ Service	Paper Requirements	OPG Meeting Presented at	*Outcomes*	Date to be brought back to OPG 2nd Review	*Outcomes*	Date to be brought back to OPG 3rd Review	*Outcomes*	Date to be brought back to OPG 4th Review
4198 - HEPMA (Alison Wilson)	Corporate Services/ Support Services	Update report following OPG tolerating risk for 6 months	15/05/2023	Board decision to tolerate this risk for 1 year, risk register updated accordingly	~~13/11/2023~~ 08/01/2024	No paper received. Deferred to next meeting 08/01/2024 - OPG agreed to tolerate the risk; risk ownership to be escalated to Lynn McCallum	**03/06/2024**		
835 - LD inpatient beds (Simon Burt)	Mental Health	Update report following OPG tolerating risk for 6 months	17/04/2023	OPG agreed to tolerate and request update in 6 months	~~02/10/2023~~ ~~16/10/2023~~ ~~30/10/2023~~ ~~08/01/2024~~ ~~05/02/2024~~ ~~04/03/2024~~ **06/05/2024**	OPG cancelled 02/10/2023, new date issued. 16/10/23 - no update received, new date issued 30/10/2023 - no update received, new date issued 08/01/24 - No update received, new date issued 05/02/24 - No paper received, new date issued 04/03/2024 - Request from Risk Owner for paper extension			
4430 - Lindean patients admitted to Huntlyburn ward (Sarah Macfarlane)	Mental Health	SBAR as to how we are mitigating this risk longer term	~~15/05/2023~~ 12/06/2023	Risk escalates and de-escalates as required. Deep dive into data to establish actions to be taken. Tolerate for 3 months	~~18/09/2023~~ ~~02/10/2023~~ ~~16/10/2023~~ 30/10/223	OPG cancelled 18/09/2023 – paper postponed due to agenda run over 02/10/2023 - new date issued. 16/10/23 - no update received, new date issued 30/10/2023 - No other mitigating actions in place and no other external facilities. OPG agreed to tolerate for 12 months with agreement any issues to be brought back to OPG	**04/11/2024**		
1297 - Estates Staffing (Gavin McLaren)	Corporate Services/ Support Services	Update report following service review postponement until 2024	~~18/09/2023~~ ~~16/10/2023~~ 13/11/2023	16/10/2023 - No paper received; new date issued. 13/11/2023 - Risk requires reassessment following actions put in place with expectations this will reduce to a high risk. OPG agreed to tolerate until	~~05/02/2024~~ **03/06/2024**	05/02/2024 - Risk Owner requested paper be pushed back			

				February 2024 to allow time for reassessment.					
4391 - Failure to meet SHTM guidance (Gavin McLaren)	Corporate Services/ Support Services	Update report following service review postponement until 2024	~~18/09/2023~~ ~~16/10/2023~~ 13/11/2023	16/10/2023 - No paper received; new date issued. 13/11/2023 - Risk requires reassessment following actions put in place with expectations this will reduce to a high risk. OPG agreed to tolerate until February 2024 to allow time for reassessment.	~~05/02/2024~~ **03/06/2024**	05/02/2024 - Risk Owner requested paper be pushed back			
4582 - Flooring across NHS Borders (Gavin McLaren)	Corporate Services/ Support Services	ITU corridor flooring replaced; awaiting access to other areas through decant	~~18/09/2023~~ ~~16/10/2023~~ 13/11/2023	16/10/2023 - No paper received; new date issued. 13/11/2023 - Update given for short term solution to reduce risk. A longer term solution still to be identified. Risk to be re-assessed following works. OPG agreed to tolerate until February 2024.	~~05/02/2024~~ **03/06/2024**	05/02/2024 - Risk Owner requested paper be pushed back			
1460 - Fire compartmentation (Gavin McLaren)	Organisation Wide	Update report following OPG tolerating risk for 3 months	~~18/09/2023~~ ~~16/10/2023~~ 13/11/2023	16/10/2023 - No paper received; new date issued. 13/11/2023 - Risk requires reassessment following actions put in place with expectations this will reduce to a high risk. OPG agreed to tolerate until February 2024 to allow time for reassessment.	~~05/02/2024~~ **03/06/2024**	05/02/2024 - Risk Owner requested paper be pushed back; risk will reduce to High following reassessment			
949 - Violence and Aggression (Sue Keean)	Organisation Wide	Update report following OPG tolerating risk for 6 months	~~13/11/2023~~ 11/12/2023	13/11/2023 - Deferred to next meeting as no one available to speak to paper 11/12/2023 - Update given for overarching V&A risk assessment highlighting the need for local V&A risk assessments. Also highlighted HSE proactive inspections around V&A and M&H. Encouraged services to book staff on to training and asking for training bookings and local risk assessments to be completed by Feb 2024. OPG agreed to tolerate this risk for 6 months.	**03/06/2024**				

4397 - ED Capacity (Bhav Joshi)	Acute	Update report following OPG tolerating risk for 6 months	24/07/2023	OPG tolerated this risk for 2 months	04/09/2023	OPG agreed to tolerate until completion of ED Workforce Review	**06/05/2024**		
4502 - Dietetics service capacity (Vanessa Hamilton)	AHPs	Update report following escalation to BET	~~02/10/2023~~ ~~16/10/2023~~ ~~30/10/2023~~ ~~11/12/2023~~ 08/01/2024	OPG cancelled 02/10/2023, new date issued. 16/10/23 - no update received, new date issued 30/10/2023 - no update received, new date issued 11/12/2023 - no paper received, new date issued 08/01/24 - Verbal Update - decision from BET to tolerate the risk whilst a service review is undertaken	**06/01/2025**				
4513 - De-registration of dental patients (Adelle McElrath)	P&CS	Update report following OPG tolerating risk for 3 months	15/05/2023	Presented at OPG for information to be bought back to OPG for update	21/08/2023	OPG agreed to tolerate for 3 months	~~13/11/2023~~ 11/12/2023	13/11/2023 - Paper not received. Deferred to next meeting 11/12/2023 - Situation slightly better following introduction of dental payment reform, although still a very high risk at present. OPG agreed to tolerate for 6 months.	**03/06/2024**
4114 - Children's Therapy Unit (Paul Williams)	AHPs	Update report	~~07/08/2023~~ ~~04/09/2023~~ 18/09/2023	No paper received; new date issued. Verbal update postponed. 18.09.23 - Update given. OPG agreed to tolerate for 6 months due to external factors	04/03/2024	04/03/2024 - Verbal update given; Eildon Housing now taking forward re-establishment of this unit. Work to commence in March 2024 with max completion deadline of May 2024. Agreement to tolerate until June 2024 whilst actions underway.	**03/06/2024**		
4427 - Community Hospital Staffing (Andrea Johnstone)	P&CS		~~02/10/2023~~ ~~16/10/2023~~ ~~13/11/2023~~ 08/01/2024	OPG cancelled 02/10/2023, new date issued. 16/10/23 - no update received, new date issued 13/11/2023 - no paper received, new date issued 08/01/24 - OPG agreed to tolerate the risk for 6 months noting the actions being undertaken to mitigate the risk	**01/07/2024**				

4554 - Staffing in Haematology (Diane Keddie)	Acute		24/07/2023	OPG tolerated for 2 months	18/09/2023	OPG tolerated for 6 months	**01/04/2024**		
4624 - Staff wellbeing in Haematology (Bhav Joshi)	Acute		24/07/2023		18/09/2023		**01/04/2024**		
4557 - Vaccination Funding (Nicola Macdonald)	P&CS		21/08/2023	OPG to tolerate for 6 months	05/02/2024	OPG agreed to tolerate the risk and request update in 3 months	**03/06/2024**		
4658 - P&CS premises risk (Rob Cleat)	P&CS		~~02/10/2023~~ ~~16/10/2023~~ 11/12/2023	OPG cancelled. 02/10/2023, new date issued. 16/10/23 - no update received, new date issued 11/12/2023 - Discussion around prioritisation of Capital and IM&T to support this work that will be legally required April 2024. P&CS unable to progress this work without these teams and has now to implement clinical prioritisation of services utilising health centres. This could potentially impact on front door. OPG agreed to tolerate for 4 months.	**01/04/2024**				
4561 - NHS Borders Water Safety Management (Gavin McLaren)	Corporate Services/ Support Services		~~08/01/2024~~ ~~05/02/2024~~ **03/06/2024**	08/01/24 - no update received, new date issued 05/02/2024 - Risk Owner requested paper be pushed back; risk will reduce to High following reassessment					
4676 - PCIP Bundle Implementation (Cathy Wilson)	P&CS		~~27/11/2023~~ 11/12/2023	11/12/2023 - Verbal update, this risk requires re-assessment and to be bought back to OPG in February	~~05/02/2024~~ ~~04/03/2024~~ ~~01/04/2024~~ **06/05/2024**	05/02/24 - no paper received; new date issued 04/03/2024 - request from Risk Owner for paper extension 01/04/2024 - request to push back due to A/L			
4686 – Dietetics Weight Management Service Sustainability	AHPs		11/12/2023	11/12/2023 - Request for £140,000 of risk fund to sustain current staffing model for additional 6 months until service review completed following reduction in service funding by £400,000. OPG asked service to re-assess risk and risk level given	~~08/01/2024~~ ~~05/02/2024~~ 04/03/2024	08/01/24 - no update received, new date issued 05/02/24 - no paper received; new date issued 04/03/2024 - Verbal update given. Service redesign underway to ensure service delivey within funding	**06/05/2024**		

				the funding gap/sustainability issues outlined. If this meets risk fund criteria this will be escalated to BET for decision. OPG queried whether they could support as this straddled 2 financial years and no confirmation has been made by NHSB whether there will be a risk fund next year. OPG to tolerate this risk until re-assessed. To be brought back to next meeting.		constraints; risk to be updated once new model implemented. Agreement to tolerate until May 2024.			
4491 - BMC Preparation/Support Spaces Environment (Lynda Taylor)	Acute		~~01/04/2024~~ **06/05/2024**	01/04/2024 - request to push back due to A/L					
4492 – BMC Treatment Spaces Environment (Lynda Taylor)	Acute		~~01/04/2024~~ **06/05/2025**	01/04/2024 - request to push back due to A/L					
4574 – ED OOH Reception Staffing (Diane Keddie)	Acute		**06/05/2024**						
4720 – CL3 Suite Exposure (Diane Keddie)	Acute		05/02/2024	OPG agreed to tolerate the risk until the HSE inspection has been undertaken, noting this is likely to result in an improvement notice; to be brought back in 3 months	**06/05/2024**				
4723 – MRI & CT Capacity (Lesley Wilson)	Acute		**06/05/2024**						
4684 – Failure of Clinical Chemistry Service Provision (Diane Keddie)	Acute		**06/05/2024**						
4721 – CL3 Suite exposure due to equipment failure (Diane Keddie)	Acute		05/02/2024	OPG agreed to tolerate the risk until the HSE inspection has been undertaken, noting this is likely to result in an improvement notice; to be brought back in 3 months	**06/05/2024**				

4693 - Delivery of SACT (Lynda Taylor) **IN DEVELOPMENT**	Acute		05/02/2024	OPG agreed to tolerate and request update in 3 months following management of risk through system	**06/05/2024**				
4728 - Face Fitting Service (Robin Brydon)	Support Services	Verbal update required following escalation to BET for decision	**01/04/2024**						

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 August 2024**
Title:	**Medical Education Report: April 2023-March 2024**
Responsible Executive/Non-Executive:	**Dr Lynn McCallum, Medical Director**
Report Author:	**Dr Olive Herlihy, Director of Medical Education**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

As per the Medical Education Report

2.2 Background

As per the Medical Education Report

2.3 Assessment

As per the Medical Education Report

2.3.1 Quality/ Patient Care

As per the Medical Education Report

2.3.2 Workforce

As per the Medical Education Report

2.3.3 Financial

As per the Medical Education Report

2.3.4 Risk Assessment/Management

As per the Medical Education Report

2.3.5 Equality and Diversity, including health inequalities

As per the Medical Education Report

2.3.6 Climate Change

As per the Medical Education Report

2.3.7 Other impacts

As per the Medical Education Report

2.3.8 Communication, involvement, engagement and consultation

As per the Medical Education Report

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development.

- Clinical Governance Committee, 10 July 2024

2.4 Recommendation

The Board is asked to formally demit responsibility for Medical Education scrutiny to the Clinical Governance Committee to provide assurance to the Board.

3 List of appendices

The following appendices are included with this report:

- Appendix No, Medical Education Report

NHS Borders

Meeting:	**Clinical Governance Committee**
Meeting date:	**Wednesday 10 July 2024**
Title:	**Medical Education Report: April 2023-March 2024**
Responsible Executive/Non-Executive:	**Dr Lynn McCallum, Medical Director**
Report Author:	**Dr Olive Herlihy, Director of Medical Education**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

2.1.1 Medical education is responsible for the organisation and administration of teaching, training and wellbeing of undergraduates (UG, medical students) and postgraduate (PG, trainee doctors)) based at the BGH. Medical Education is responsible for the administration of ACT funds which include the cost of accommodation for medical students placed in GP practices across the Scottish Borders. Our role is also to ensuring all trainers have access to training thus maintaining recognition of trainer (ROT) status to enable them to continue to provide supervision to both UG and PG trainees in the provision of a supportive environment for learning. This report aims to provide an update on the changes/advancements in UG/PG education highlighting areas of good practice and areas of concern and actions taken. And to provide an update on trainer status and any improvements or concerns in this area. This report covers the period 1st April 2023 to March 31st, 2024.

2.2 Background

2.2.1 As a Local Education Provider, NHS Borders must abide by GMC Standards for training and education. The presence of red flags in the National training survey (NTS) or Scottish training surveys (STS) may lead to NES enquiries from the quality review panel (QRP) whose purpose is to ensure standards are being met to improve the quality of training. Persistent red flags in areas can trigger a Quality visit where the panel will review the training experience, identify and promote areas of good practice as well as support the introduction of measures to develop and improve training. NES will maintain contact with the Director of Medical Education (DME) to ensure progress against the action plan and a further review is made at the QRP. If there is no progress against an action plan, NHS Borders, as a local education provider (LEP) can be referred to the GMC for enhanced monitoring. This in turn will lead to increased monitoring of the national data and information relating to training with more frequent Quality Improvement (QI) visits (usually 6 monthly) with NES and a GMC representative.

2.2.2 The DME provides an annual report to NES (DME report) in response to the NTS, STS and undergraduate survey reports using local information from focus feedback groups and Trickle[1] to triangulate information to support areas of good practice and areas where training is more challenging. It is important to ensure that we, as an LEP can provide a supportive and positive learning environment for our trainees with a good balance of educational and service roles. Thus promoting NHS Borders as an excellent place of training and helping to support succession planning of future consultants.

2.2.3 The importance of medical students locally cannot be over emphasised as these are the doctors of the future and potentially trainees for NHS Borders. By creating a supportive training environment, we will encourage students to return as trainees in the future as we have done in previous years.

2.3 Assessment

2.3.1 **Undergraduate Training**
The UG medical education report is based on feedback collated by the university during the year for the groups attached to the specialities. This year feedback was mainly positive but unlike previous years NHS Borders did not receive any good practice letters.

2.3.2 One area of consistent negative feedback relates to computer access when students are working on the wards. To combat the negative feedback with respect to access to computers Medical Education successfully bid for Associated Costs of Teaching (ACT) funding to purchase i-pad lockers and i-pads for student access to University resources and learning. However, setting this up in both medicine and surgery provide difficult. Additionally, the i-pads did not get access to the NHS Borders network so students couldn't use them for clinical work. The locker in medicine was not used and has since been rehoused to the library. The intention is to try and source laptops to enable assistantship students to use the laptops during this period. There are still

[1] Trickle is an employee engagement and wellbeing platform that allows open, honest and anonymous feedback from trainees. This enables real time resolution of issues and speedy development of improvements. https://trickle.works/

some concerns re access to Public WiFi in the BGH and Chaplaincy (where weekly teaching and induction are conducted). Improvements to the WiFi in the accommodation used by medical students have been very well received. WiFi access in accommodation used by trainee doctors is poor and a source of complaints. Medical Education is looking into this currently with Estates and IM&T.

2.3.3 Student expansion: There was an increase in medical students attached to practices in Galashiels. Medical Education sourced housing within the BGH accommodation for these students so they would be near their colleagues. For the coming year Edinburgh university has increased its student's numbers in GP by 100%. ACT funding is retrospective so the cost of accommodation for these additional students will not be reflected in our allocations for 2024. Finding accommodation for the year ahead rather than paying for B&Bs is necessary to reduce the costs.

2.3.4 Edinburgh university has asked NHS Borders to increase our students for assistantships in 2023. There were more students than Foundation Year 1 (FY1) doctors this year so some were buddied with a Foundation Year 2 (FY2) doctor instead. Feedback was positive although some students found it difficult when their buddy was on leave. SIM teaching was developed and provided by trainee doctors to enhance the student experience and this was really well received. NHS Borders Orthopaedics Department has been asked to host 4 new students starting in August 2024.

2.3.5 St Andrews University has had approval from the GMC for their Scottish Community Orientated Medicine (SCOT COM) UG course. NHS Borders is in discussions with St Andrews to accommodate these students out with Edinburgh university allocations in 2026/27.

2.3.6 ACT Bids: NHS Borders successfully bid for the following:

- Non recurring funding for three additional study pods for the library
- Non recurring funding for seven lap-tops for the chief residents to support their work with trainees and undergraduates.
- Non recurring funding for domestic staff to support cleaning and turnaround of student accommodation at weekends to allow for early entry at the start of placements and mitigate against negative feedback.
- Non recurring funding for a clinical teacher fellow due to be interviewed in June 2024 for commencement in Aug 2024.
- Recurring funding for Simulation and clinical skills facilitator at 0.5 w.t.e.
- Recurring funding for 0.5 w.t.e for a quality officer

2.3.7 Funding to upgrade the bathrooms in the student accommodation remains ring fenced but we have been unable to engage Eildon housing to determine what aspects of upgrade are under NHS Borders' remit and what is their obligation, to enable us to proceed. This is further complicated by the fact that the lease is scheduled for renewal in 2028.

2.3.8 With the increase in medical student numbers, ACT funding has increased. Following a series of stakeholder engagements to review ACT funding and allocation, NHS Education for Scotland (NES / Scotland Deanery) has proposed creation of a national pot to allow smaller Boards in particular to bid for funding for large projects which could not be funded from the existing ACT allocation. This could be used to address

the shortage of accommodation - a limiting factor for NHS Borders and other boards - as student numbers expand.

2.3.9 Accountability Report: Medical Education will need to feedback on the slippage spends on study pods, bicycle shed and bicycles, simulation kit and i-pad lockers purchased with ACT monies **(appendix 1).** However, these projects have been slow to progress, so we have not been in a position to obtain feedback. Medical Education will need to feedback on the non-progression of student bathroom upgrades but this can be explained on the basis that we need to negotiate with Eildon with respect to the status of the accommodation and we are currently looking at options. With respect to accounting for existing ACT monies the Medical Education team continue to work with speciality units, albeit that we have made less progress in the recent year due to depletion of the team. The objective is to quantify supervision and teaching and apply a cost to each of the units. This has presented difficulties in the medical unit as Job planning progresses (see Trainer section). Specifically, trainers advise they do not have time in their job plans to undertake this role and need to be assured that the monies are within the medical unit budget.

2.3.10 Administration support for UG in the medical and surgical units remains problematic. Identifying staff who can support the consultants/trainers in organising speciality time tables remains a challenge. Medical education has supported general medicine in recent years but have struggled in the last year to do so due to loss of staff within the team. This makes obtaining feedback more difficult. It is Medical Education's understanding that ACT monies had previously been allocated to unit secretaries to support UG administration but the trail for this has not been identified and there is no capacity within the secretarial units currently to support it.

2.3.11 Following successful bids for additional funding for additional SIM kit and the appointment of a SIM tech in July 2022 the SIM programme locally for UG has been enhanced significantly with positive feedback. **Appendix 2**

2.3.12 School students: Medical Education ran its first 'introduction to medicine' for school's students in July 2023. This was followed by mock interviews for students preparing for medical student applications in November. There was a very supportive response from colleagues and the day was successful with positive feedback. We hope to run it again this year and moving forward will involve the Clinical Teaching Fellow (CTF) in consolidating this programme and ensuring we get a wide representation from all Scottish Borders schools.

2.3.13 There was a hiatus of Physicians' Associates (PAs) students for 2023 but we have been approached by Aberdeen university to provide rotations for PAs trainees for 2024_25.

2.3.14 Post Graduate Education

The DME report (appendix 3,4) continues to be split into 2 parts with separate timelines. Part 1 relates to governance structures and includes how the board is made aware of educational developments and concerns. Part two focuses on feedback from the NTS (National training survey) and STS (Scottish Training Survey) surveys including evaluation of induction, supervision, teaching, rota, team working, workload, and satisfaction. The report required feedback on specialities performing in the top or bottom 2% of these surveys. While red or pink flag may be seen in other specialities, we are no longer required to comment on these within the report. However, we are

seeing more DME enquiries following the QRPs (Quality Review Panels) for these specialities.

2.3.15 The quality visit to the obstetrics and gynaecology department triggered by changes in the NTS survey was held on the 23rd March 2023. A pilot survey of previous trainees had been carried out late in 2022 by NES to get a better understanding of the concerns. Medical Education worked with the department to address these concerns. At the time of the triggered visit many improvements had taken place and as a result the visit was a very positive one where NES felt training was prioritised and all opportunities maximised for learning. No further visit was recommended. **Appendix 5** A good practice letter was received for the obstetrics and gynaecology department following feedback from the NTS survey later in 2023 from all Trainees, reflecting 4 or more green/light green flags for:

- Clinical Supervision out of hours
- Feedback
- Handover
- Overall Satisfaction
- Reporting Systems (DATIX)
- Supportive Environment
- Work Load
- Teamwork
- Educational Governance
- Rota Design.

2.3.16 Surgery received a good practice letter based on feedback from the National training survey (NTS) Foundation Year. Areas highlighted included:
Clinical Supervision out of hours
Educational Governance
Rota Design and Teamwork.

2.3.17 General (Internal) Medicine (GIM) once again received an enquiry with respect to all trainees specifically in relation to teaching and the teaching environment. Despite an increase in the number of trainees/non-training doctors on the rotas, there continues to be short sickness absences across all rotas, impacting on service delivery and workload as well as the ability of trainees to access teaching and supervision. The response to this was delayed due to staffing and on discussion with NES it was felt to be low level and no response was necessary on this occasion. Free text comments were also received with respect to patient safety within the medical unit, but no specific detail was given and on investigation this was not the view of other trainees.

2.3.18 Psychiatry also received an DME enquiry with respect to clinical supervision, induction and the educational environment. **(Appendix 6).**

2.3.19 The Clinical Development Fellow (CDF) programme has been operational for a number of years and is growing in popularity with trainees. These trainees, many who have worked in the BGH previously and keen to return, provide 80% clinical service and 20% development time. The latter is linked to Clinical Governance priorities e.g. QI and the Patient safety programme. It can also include managerial tasks (e.g. clinic rotas), teaching roles (e.g. simulation programme) or speciality aspects of training e.g. time in ITU. These posts, in all specialities play an important role in enabling provision

of a sustainable resilient rota that provides appropriate training time and achievement of curricular outcomes for our trainees.

2.3.20 Workload/Rotas: in 2023_24 concerns had been raised by the senior trainees in medicine with respect to the workload and training experience. These arose as a consequence of unfilled training posts, early resignations of training and non-training posts, short term sickness absence, Less Than Full Time (LTFT) trainees in Full Time posts and trainees requiring additional support. Significant funding was invested in the Medical CDF programme to make this rota compliant and enable the trainees to gain the required experience. The Emergency Department (ED) rota was also non-complaint, requiring investment in both CDFs and Foundation Year 2 doctors based in General Practice (GP). The Foundation trainees worked on the medical Out of Hours (OOH) rota enabling our GP trainees to support the ED rota which was felt to be more in line with their training requirements.

2.3.21 Maintaining the integrity of our rotas is dependent on the allocation of trainees from the Scotland Deanery / NES and this can vary each year due to availability of trainees. With respect to unfilled training posts, specialities are often advised at short notice, making it difficult to recruit to the unfilled post. The Southeast Directors of Medical Education (DME) have asked NES if they can advise as early as possible how many trainees in each speciality will be allocated, so gaps can be advertised. It is important to note that any recruitment locally into an unfilled training post may not be funded by NES, as these monies are to be returned to the Scottish Government. Thus, the Board needs to fund these posts.

2.3.22 The Obs and Gynae senior rota remains non complaint this year due to trainees not getting enough rest time during weekday nights. This will not be rectified in Aug. as three out of 4 posts are filled with LTFT trainees at 2.2 w.t.e. This was one of the previous issues that precipitated a NES quality visit. The department and HR are looking at possible workable solutions but all will require additional staffing which requires funding.

2.3.23 In the longer term NES is looking at distribution of trainees to give priority to smaller more vulnerable rotas such as ours, but this is not yet in place.

2.3.24 Rotas are required to be shared with trainees 6 weeks in advance of starting their post. Therefore, establishment of numbers for each rota is essential to ensure appropriate service cover and access to educational activities (e.g. theatre time, clinics, teaching) are rostered. This in turn would provide a more resilient rota with improved training experience. Medicine moves to the Allocate Rota software in August 2024, so rostering these activities will be easier and more visible.

2.3.25 Expansion posts: there have been a number of expansion posts at Foundation and GP trainee level in the last year:

- Two Foundation Year 1 doctors (medicine and surgery)
- Three GPST posts (DME, Psychiatry and Palliative medicine)
- Six Foundation Year 2 posts to contribute to out of hours only, as based in GP practices in the Borders during the day.

This means an increased need for supervision and ensuring there are enough trainers trained in the supervision of GP trainees and in particular navigation of their portfolio. Training for trainers was scheduled in the CME programme for January 2024.

2.3.26 Trainee Wellbeing: Improving the wellbeing of our trainees significantly improves productivity, care quality, patient safety, patient satisfaction, financial performance and the sustainability of our health services (Caring for Doctors, Caring for Patients). To support trainees and respond to concerns in real time, Medical Education secured funding for the wellbeing app Trickle from Dec 2022-2024. However, over the last year despite significant support from Medical Education and the chief residents, interest in Trickle has dropped off significantly. Therefore, Medical Education have decided not to pursue further contract for the App. Feedback from the trainees advise that the units are small and they can address their concerns with appropriate staff as they arise or raise them at the junior doctor's forum. Attendance at focus groups has also been poor and Medical Education has looked at other ways to improve attendance. One area we are currently considering is to ask our clinical fellows to support the focus groups within each department going forward.

2.3.27 Quality Improvement (QI) symposium was held in July. Trainees submitted abstracts which were scored by a panel of consultants and presented by the trainees. Prizes were awarded for the best QI projects. This is now an annual event and trainees are made aware of it on commencement of their posts. Funding of prizes is support by the PJL endowment fund and the post graduate education fund. The latter is to be closed and reorganised in the small grants programme. Following this year's QI symposium, the team have produced a journal of all presentations which will be shared with all staff and published on our social media sites and Med Ed web page.

2.3.28 Advancing Equity in Medicine: Scotland's Softer Care, Safer Landing has been used to support International Medical Graduates (IMGs) since its inception in 2021. In addition, we have a local support group led by Dr Andrew Duncan and Mr Srihari Vallabhajousula. It has not been an easy task to engage with our IMG trainees to address their training needs. Successful sessions have been run on Working in a Busy ED, Portfolio Management and How to get the best out of Your Educational Supervisor.

2.3.29 An IMG WhatsApp group has helped trainees make their own professional and social links. Our survey on topics and timings for meetings has helped with initial engagement but this has tailed off towards the end of the year. There is an agreed procedure for welcoming IMGs and following their progress in the first few months based on a model in use in NHS Fife. Anonymous feedback from the survey has been passed back to the Clinical Leads. Supervisors have been encouraged to use the Softer Landing, Safer Care resources to help our IMG's settle into their new posts. Attempts to use Artificial Intelligence Software to enhance Communication Skills have been thwarted by our inability to get Management to sign a contract with the external provider, despite funding being allocated. Medical Education continues to pursue this.

2.3.30 Trainers With respect to ongoing recognition of trainers (ROT) status, supervising consultants are expected to provide evidence over a 5 year cycle against the 7 GMC Domains. Maintenance of ROT is essential to allow doctors to supervise trainees. Feedback on the MIAD courses (on line training the trainer courses) has been very positive. The SE DMEs have brokered a deal with the company to provide these at a nominal cost to the trainer which is supported by the study budget locally.
Not all consultant or non-consultant staff have ROT status which reduces those available to supervise trainees. Consequently, those that have ROT need to supervise

more. The current tariff for supervision of trainees or students is 0.25 PA with a max of 4 per trainer. Most departments manage without difficulty. However, within General Medicine there is a short fall of trainers to support trainees, necessitating those who are present to supervise more than the previously agreed 2 trainees. The increase in medical students and trainees is increasing the need for more supervisors so it is imperative that time is allocated appropriately in job plans for supervision.

2.3.31 Medical Education recommenced the CME programme for medicine in October 2023. Other departments continue to run their programmes successfully but Medicine had slipped due to service pressures. Topics included Valued-based health care, Right decision service, race and equality, GP supervisor training, Clinical Educator programme. However due to a shortfall in Medical Education staffing and low attendance, these sessions could not be supported from the start of 2024. Medical Education will revisit CME for trainers in the coming year. The IMG group ran a session of Enhanced Communication for Health (EC4H) on managing difficult conversations with trainees for educational supervisors with a significant focus on trainees with neurodiversity which was well attended by trainers.

2.3.32 Quality/ Patient Care

Improving the experience of trainees in NHS Borders and looking after their wellbeing impacts positively on patient care and safety. Importantly these are the doctors of the future and a positive experience will support recruitment and retention for the future.

2.3.33 Workforce

Creating an open honest, supportive culture will help recruit and retain an important NHS workforce.

2.3.34 Financial

All Boards have to meet the requirements of a Performance Management Framework to receive Medical ACT funding, including an annual accountability report which covers:

1. Actual Medical ACT expenditure for the previous financial year
2. Up-to-date baseline budgets for Medical ACT showing the allocation to each specialty/department
3. Measurement of Teaching compliance

It is important that this funding is used for the provision of medical education as above

2.3.35 Risk Assessment/Management

Ensuring a structured, inclusive positive experience for medical students and trainees supports a future work force.

Providing transparency on ACT fund spending is integral to continued funding. Improving the educational and clinical experience of trainees impacts positively on patient care and service delivery and is the corner stone for future recruitment within NHS Borders. It also ensures our position as a training hospital.

Clinical supervision should be a priority in SPA time in job plans as without adequate supervision, trainee allocation by NES will be impacted. Currently all services are trainee-dependent for delivery.

2.3.36 Equality and Diversity, including health inequalities

Health Inequalities Assessment not required for this report.

2.3.37 Climate Change

None Identified.

2.3.38 Other impacts

Ensuring a positive training experience for all trainees is an important for future recruitment at all levels.

2.3.39 Communication, involvement, engagement and consultation

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

The DME attends the Scottish DME bimonthly meetings. This group has shared representation in national committees so that all relevant information can be communicated at these meetings:

These groups include

- Foundation Programme Management Group (FPMG) – DME NHS Borders representative
- National Association of Clinical Tutors (NACT UK)
- Quality Review Panel for specialties
- Scottish Association of Medical Directors
- SAS Doctors Development Group
- Realistic Medicine – DME NHS Borders representative
- ROT working group
- Scottish Shape of Training transition and implementation group
- Doctors and Dentists in Training (DDiT)
- Advancing Equity in Medicine

2.3.40 Route to the Meeting

Shared national issues in relation to training which impact locally are discussed at national meetings and resolutions agreed as appropriate. Local DME reports are not shared nationally.

2.4 Recommendation

2.4.1 Medical Education asks the Clinical Governance Committee to acknowledge the progress in Medical Education facilities and experience and to support the team in continuing to improve the quality of training for all training and non-training grade doctors working at the BGH. Specifically, Medical education would ask the committee to:

- Recognise the challenges as a consequence of the increase in student numbers on accommodation both centrally and in the community and support Medical Education in seeking a solution
- Recognise the importance of achieving sustainable and resilient rotas throughout the organisation for the benefit of the trainees and patients.
- Recognise the challenge of trainers to provide supervision for trainees and the impact of not doing so on trainee allocation to NHS Borders with the understanding that currently, all acute services are dependent on trainees to function. The ask is that supervision is prioritised in SPA time in job planning.

Awareness – For Members' information only

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- **Appendix No 1, Accountability report**
- **Appendix No 2, Simulation for Undergraduates**
- **Appendix No 3 & 4,DME Reports**
- **Appendix No 5 BGH OG Visit**
- **Appendix No 6 DME Enquiries**

Appendix 1 -Accountability report

2022/23

Accountability Report

NHS Board: Borders

Completion Guide

Section	Guidance / information
1a	**Summary –** if any changes need to be made, please amend within the below excel spreadsheet.
1b	**Signatures** - email approval or signature accepted.
2a	**Evaluation** – NES acknowledges that evaluation may not be possible within the timeline of the current report; please highlight when evaluation may be expected, if this has been requested. Please also note that evaluation of bids from previous years can also be reported within this section.
3a	Responses made in last year's report have been pre-populated in this section. Please include any relevant additional information to reflect changes made in year or confirm if no changes are needed. **Governance arrangements** – Interface between local (or equivalent groups) and regional ACT groups/practices,
3b onwards	**Factors affecting Medical ACT in Boards** – outline any novel initiatives, opportunities, challenges, and any anticipated changes to teaching arrangements or updates to curriculum. The intention is to collate responses from all Boards to provide an opportunity for sharing intelligence by highlighting common challenges and potential solutions. Please provide brief and concise responses to these sections; bullet point format is acceptable. Any relevant metric data to support statements would be much appreciated.

Section 1a – summary

Confirmation of Allocation of Funding	Recurrent	Non Recurrent*	Total
Base allocation adjusted for regional transfers	£795,937		£795,937
2022/23 Recurrent funding available for recurrent and non recurrent bi	£0		£0
2022/23 Non recurrent funding available for non recurrent bids only		£15,568	£15,568
2022/23 HCP medicine funding		£15,813	£15,813
Additional Pay uplift	£22,403		£22,403
Initial Allocation Available to Board	**£818,340**	**£31,381**	**£849,720**
Total Funding Available for Bids in 22/23 inlcuding additional Pay uplift and HCP med			**£53,783**

Confirmation of Funding Received	Recurrent	Non Recurrent*	Total
Base Costs	£795,937		£795,937
Bids Approved by RAWG and NES	£22,403	£22,310	£44,712
In year slippage			£0
Total Funding Received	**£818,339**	**£22,310**	**£840,649**

Section 1b – sign off

Director of Finance

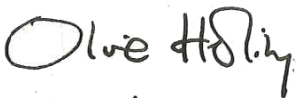
Additional comments on this year's submissions

Signed: 	Please insert scanned/electronic signature or email approval of submission accepted

Print name: Andrew Bone	
Date: 18th September 2023	

Director of Medical Education

Additional comments on this year's submissions

Signed: 	Please insert scanned/electronic signature or email approval of submission accepted

Print name: Dr Olive Herlihy	
Date: 13/09/2023	

Section 2a supplementary – prior year evaluations

	Evaluation of Prior Years Bids Not Previously Shared with NES	
Proposal/Item Description	Year Bid Submitted (NHS Financial Year)	Detail Results of Evaluation

Section 2a – bids

To be completed in excel document.

ACT Accountability Report- Borders 2022

Section 2b – other

To be completed in excel document.

Section 2c – baseline spend

To be completed in excel document.

Section 3 – mandatory questions

Local Governance Structure

a Does the Board hold Local Medical ACT meetings?

Responses made in last year's report have been pre-populated in this section. Please include any relevant additional information to reflect further changes for 2022/23 or indicate if no changes are needed

Yes.

Provide brief details of the Board's local governance structure for Medical ACT and how this feeds into RAWG business

Responses made in last year's report have been pre-populated in this section. Please include any relevant additional information to reflect further changes in 2022/23 or indicate if no changes are needed

Decisions regarding the use of Medical ACT monies is discussed within the medical education team initially. Once the proposal is agreed at this level it is then brought to the board through the medical director for approval. Once approval is agreed this is followed by discussions with appropriate departments (if necessary) to carry out the required piece of work relating to the proposal. The proposal is then discussed at regional group for approval before proceeding. NHS Borders is represented by the DME (Dr Olive Herlihy), Medical Education Manager (Kath Liddington) and local Finance representative (Donna White) for ACT at Regional ACT meetings. If the DME is unable to attend, then this is delegated to the ADME (Dr Andy Duncan). Finance and Med Ed manager will liaise to ensure the presence of one or the other.

b	Please provide details of any Medical ACT funded activities/initiatives which have been beneficial and potentially transferable to other Boards – GENERAL COMMENTS

Please provide details of any Medical ACT funded activities/initiatives which have been beneficial and potentially transferable to other Boards – TO INCREASE CAPACITY FOR LEARNING

c	Please provide a brief overview of any opportunities/challenges IN YEAR which have impacted on the delivery of Undergraduate Medical Education in the Board

Because of the rising cost of bed and breakfast accommodation we have taken up a recent opportunity to acquire additional accommodation in the residences on the BGH campus. Up to 4 medical students on GP placements in Galashiels and Earlston will be offered accommodation close to other medical students on placement at the BGH. This will support their wellbeing and avoid potential isolation as they join the wider community of students in NHS Borders.

Going forward we hope to employ a clinical fellow to support teaching but funding is limited for this.

Please provide details of any ANTICIPATED FUTURE challenges which may impact the delivery of Undergraduate Medical Education in the Board

The supply of accommodation on the BGH campus is limited and demand is high and is growing. Availability of accommodation will be a limiting factor for future expansion of student numbers. This has been discussed with local, regional and national stakeholders and partners.

Please provide a brief overview of any issues that have prevented the Board using its full Medical ACT allocation for 2022/23

d	Please provide details of any anticipated changes to Undergraduate teaching and/or curriculum in the forthcoming academic year which could impact Medical ACT in your Board.

e	Please provide a brief overview of any barriers you have encountered to you using your full Medical ACT additional allocations

Appendix No 2 Simulation education delivered to medical students

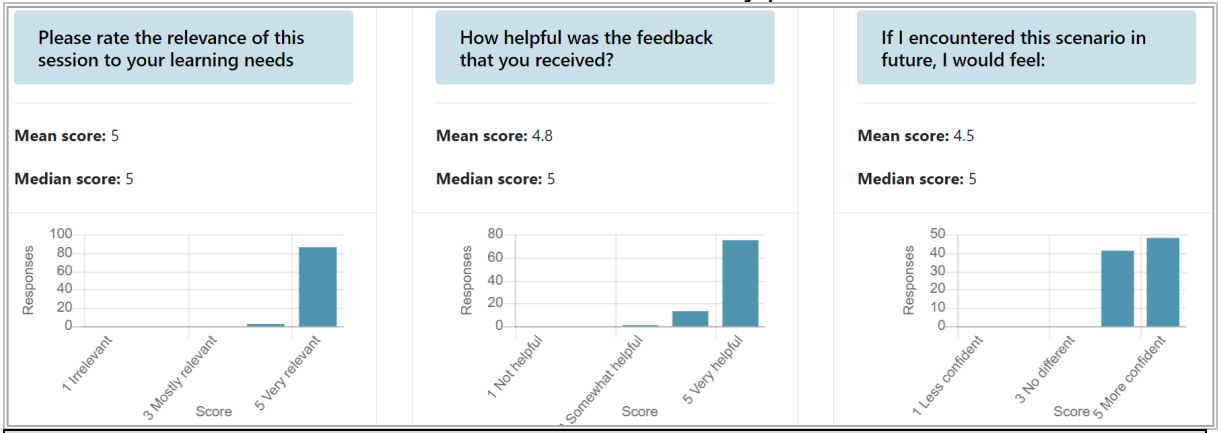
April 2023 and March 2024

During the last year, 82 simulation education sessions were conducted involving 431 medical student attendances (some may have attended more than one simulation session). The majority of courses took place in the clinical skills suite in the Education Centre; some in situ simulation was also completed in BGH. Courses include:

Simulated scenarios	Medical Students
Acute cholecystitis recognition	12
Acute pancreatitis recognition	22
Appendicitis recognition	25
Hyperactive delirium	47
P - Bronchiolitis in baby	21
P - Paediatric Sim - diabetic ketoacidosis	8
P - Paediatric Sim - sepsis	34
P - Recognition of asthma & treatment	38
P - Unconscious paediatric patient	25
Parkinson's disease	34
Pulmonary oedema	48
Recognition of acute asthma	17
SIM 3 - COPD Exacerbation	8
SIM 3 - Management of seizures	8
Urosepsis and acute kidney injury	35
Wound dehiscence	25
Medical Students On call Simulation	17
Small bowel obstruction	7
Grand Total	431

P=Paediatric simulation

The feedback from these sessions has been extremely positive:



Great session, loved the face overlays/wounds - made it feels more real
This teaching was incredibly helpful and much appreciated. Matthew was such a good teacher - really useful to talk through in a succinct way management of the key conditions that came up (especially AF recap) and he answered all questions that we have in a way that made so much sense. Thanks so much!
Lots of time to debrief all stations and got good quality feedback

Thank you so much this was genuinely so helpful, really different scenarios than we have experienced before. Matt's acting was also much appreciated - really helped us to get into the scenario!
Keep surprising us
Continue with the stressful environment that was very realistic but enjoyable
This session was planned out very well!
Thoroughly enjoyed practice of on call scenario

The Simulation Technician, Rod Mcintosh and the recently appointed the Clinical Practice Educator for Simulation, Jill Rose, supported 28 Faculty – from the clinical lead for simulation and Associate Director of Medical Education, Dr Andy Duncan, to fellow consultants in Medicine, DME, Stroke Unit and Surgery, Clinical Development Fellows and a wide range of doctors in training, including Foundation Year 1 doctors.
In August every year newly arrived doctors in training are offered "Introduction to Simulation". This helps doctors in training to achieve educational outcomes to meet curricular requirements and also contributes to making the service sustainable. Investment in staff and equipment funded through medical ACT has created a very effective and popular service with an excellent reputation. We will continue to improve the service by adding to the current range of scenarios, involving a wider range of specialties and ensuring the simulation team and faculty are well trained and aware of innovative practice across NHS Scotland as the service is continually developed.

Medical Education Simulation Team and Faculty
June 2024

Appendix No 3 & 4,DME Reports

Scotland Deanery

Director of Medical Education Report

NHS Board	Borders			
Responsible Board Officer	Dr Lynn McCallum			
Director of Medical Education	Dr Olive Herlihy			
Reporting Period	**From**	3 August 2022	**To**	1 August 2023

Note to DME: Please complete all sections of the report in relation to the last training year. For assistance, please contact Alex McCulloch at alex.mcculloch@nhs.scot.

Please complete and return to alex.mcculloch@nhs.scot by **5pm Wednesday 14 June 2023.**Educational Governance

1.1 Does the full Health Board itself receive a regular report to support its governance responsibilities around the quality of postgraduate and undergraduate medical education and training?

- **How often does it receive a report around educational governance?**
- **What is covered in these reports?**
- **Is there a board member with responsibility for MET?**

A medical education report is provided annually to the Clinical Governance & Quality committee of the Health Board and once approved at this forum it is then presented to the full Health Board for ratification and action as appropriate.
All aspects of medical education are covered including undergraduate training report, post graduate training and a trainer's report.
Dr Lynn McCallum as Medical Director is responsible for Medical Education training.

1.2 Is there a Health Board committee with responsibility for the governance around the quality of postgraduate and undergraduate medical education and training?

- **What is it called?**
- **How often does it meet?**
- **What data and information is considered by this committee?**

The Clinical Governance & Quality Committee of the Health Board has responsibility for the governance around the quality of postgraduate and undergraduate medical education and training. The Director of Medical Education meets with the Medical Director every two weeks to update on progress and actions that need to be addressed and areas of concern following the

- 6 weekly medical education meeting (which has representation from the DME, ADME, Foundation Programme Director, Chief Residents and medical education team) and the
- quarterly Medical Education Governance Forum (which has representation as above, and in addition Undergraduate Module Leads and three Health Board members - the Director of Quality & Improvement, The Employee Director and a non-Executive Board member).

1.3 Is there a governance committee structure that links the delivery of education and training in LEPs to either the Health Board or the Health Board's educational governance committee? If there is, can you describe the elements of that and how information flows to the Board/Board committee? (You may wish to share an organogram if there is one that described the committee structure.)

The Medical Education Governance Forum is responsible for the strategic direction, operation and educational performance of Medical Education function in NHS Borders.
The forum meets every quarterly.
The forum monitors the overall performance of NHS Borders against the regulatory and curriculum requirements through consideration of national surveys and regular internal trainee feedback (provided by focus feedback groups, direct feedback from trainees specifically to Med Ed, the junior doctor's forum and/or through regular meetings with the chief residents) and the wellbeing App TRICKLE. This feedback is triangulated to produce an action plan. These action plans are shared with the CD of the appropriate departments for response and

completion of actions within agreed time lines. Medical education provides an annual report to the clinical governance and quality committee using this information/data and to the board as above.

1.4 Describe the quality control activities in relation to MET that have been undertaken by your HB in this training year?

Obstetrics and Gynaecology Dept: The O&G department received feedback through TRICKLE initially with respect to the rota. This was followed up by a focus feedback group to gain more detail of the concerns. This was fed back to the department to address the issues raised. Red flags noted in the national survey triggered a QRV. In the interim the quality management team in NES offered to do a small site review. The feedback was used by the department to address all the issued raised with significant improvement. The visit undertaken in March was very positive as the department were able to demonstrate the actions they had taken from the small site review feedback to improve the quality of training and overall experience resulting in a very positive constructive visit.

Surgical Department: In surgery concerns were raised about access to specific training requirements and the CD worked with the TPD to support improvements. Feedback from our local review and the national survey raised concerns with respect to aspects of training and the quality management team offered to do a small site review. On this occasion feedback from trainees and trainers was requested. This was then discussed with the surgical team by the DME and actions from the feedback are being taken forward by the team. Progress on this will be evaluated by a focus feedback group towards end June early July.

Medical unit: In medicine concerns were raised with respect to access to clinics. Medical Education worked with the medical unit SLWG with trainee representation to improve access to clinic to enable trainees to meet their requirements with success.

Accommodation: The TRICKLE app has been used to address questions/concerns in real time. Specifically, one issue raised related to accommodation. This continues to be a work in progress but a team was set up with trainee representation to ensure priority provision for trainees as needed.

1.4 Are there forums within your HB whereby senior officers (CEO, MD) or site-based senior clinical management have regular, scheduled meetings with trainee doctors to discuss their training and receive feedback? Please provide full details.

The junior doctor forum meets monthly. The chief residents meet with management /Associate Medical Director to discuss any concerns in relation to teaching and training and the chief residents have representation at senior consultant and unit meeting and attending the Med Ed Meeting 6 weekly meeting. This supports the movement of information freely between the trainees and the staff. Importantly TRICKLE has also provided a voice to the trainees in real time to facilitate their involvement in real time solutions and reducing potential negative impact on wellbeing.

1.5 How are learners made aware of who is responsible for what within education for your organisation.

The Medical Education Department meets with the trainees at each induction and the Medical Director also meets and greets the new trainees. All trainees are advised at this time who is responsible for various aspects of teaching and training locally. As each department within the hospital is small, trainees get to know everyone very quickly and also can ask if uncertain.
Medical education have an email address for queries, a twitter feed (accepting this has been less active of late due to reduction In administration staff) a notice board in the main corridor and an internet web site where all information relating to education and support is available.

1.6 If your review of quality management data highlights a number of new red flags in a particular department how do you address that?

If the survey identifies new red flags medical education reviews the focus feedback groups to identify if similar feedback was given in recent focus groups and to obtain additional detail and context. During the focus groups trainees offer potential workable solutions. Our trainee numbers are small it does not take much to change the direction of feedback so triangulation is really important to determine if the concern is consistent before invoking change. The feedback is then collated and fed back to the specific department for discussion with a request to return an action plan. A working example of this is outlined above in our obstetric department who had new red flags in the 2022 survey. Our internal process was supported by a small site review with constructive feedback and completion of actions with a positive outcome. Follow up will determine if this is maintained.

1.7 What are the mechanisms in place for trainees to receive feedback from DATIX?

Adverse Event reporting by doctors in training is proactively monitored by Medical Education on the Datix system. Adverse events reported are shared with the educational supervisor of the trainee so that the event can be discussed, any learning identified and pastoral support provided. Specific feedback with on progress can be obtained from the adverse event final approver in that clinical area, but final outcomes can be difficult to share with the reporter as the trainee has often left the organisation before the concerns have been fully addressed. The MM process is looking to incorporate DATIX in their departmental meetings to provide more timely feedback to trainees

1.8 At each site, how many trainee doctors have been involved in an SAE?

Site	Unit/Specialty	Number of SAE	Was the Deanery notified and involved in the follow up?
Borders General Hospital	DME	68287	No – the trainee identified the harm and reported the adverse event
Borders General Hospital	General Medicine	7155	Yes – NES was notified and has been involved

1.9 At each site, how many trainee doctors have required 'reasonable adjustments' to their training in relation to a declared disability?

Medicine – 3; Orthopaedics – 2

1.10 How do you ensure educators are appropriately trained and that their training is kept up to date?

Following successful funding of new and review trainer courses these continue to be available at a nominal cost which can be recouped from the Medical Training budget. The CEP programme has been updated and access to these training modules are also available. Educators are provided with regular updates of courses and Conferences they can attend to ensure maintenance of rot status. All consultants have 1 SPA per week in their job plan for education and training purposes

1.11 Describe the mechanisms in place to ensure all educators have appropriate time in their job plans to meet their educational requirements?

Clinical line managers have agreed that all trainers have 0.25 PA per trainee with a max of 1 PA for training which sits within SPA time.
1.12 What educational resources and funding can educators access?
See 1.10. Funding is available through the Medical Training budget.
1.13 Is support available to educators when they are dealing with concerns? Please provide full details.
All educators dealing with concerns have support available via Med Ed from the DME or ADME
1.14 How do you ensure there are sufficient opportunities for learners to undertake educational CPD?
The hospital has a rolling CPD programme where 4 hours every 2 months is ring fenced for CPD for local departmental CPD and hospital wide as appropriate. All scheduled clinical commitments are cancelled during this period and trainers and trainees are encouraged to attend. Teaching programmes are bleep free for GPST and Foundation doctors and ward staff are aware when teaching is on so they can support trainee to attend. STs have a local weekly teaching programme throughout the year in addition to ensuring allocation or regional teaching into their rota to support attendance.
1.15 How do you ensure there is a balance between providing services and accessing educational and training opportunities?
The CME programme has been built into the services for many years and maintained over time to support CPD for trainers and trainees as above. Study leave for CPD is provided and down to the individual trainer to balance this need with service requirements. Regional teaching for trainees is rostered into the rota Trainee education on site is bleep free and ward staff aware to ensure trainees are released. Foundation teaching is recorded on Teams where possible so that doctors unable to attend can review the session at another time. When there is pressure on service and reduced staff sue to short term sickness absence this balance is more difficult to achieve for everyone. This year we have requested an increase in our non-training grades to support service to improve access to training opportunities for trainees.

2 Sign-off

Form completed by	Role	Signature	Date
Olive Herlihy	DME		13/6/23

Director of Medical Education Report

NHS Board	NHS Borders			
Responsible Board Officer	Dr Lynn McCallum			
Director of Medical Education	Dr Olive Herlihy			
Reporting Period	**From**	3 August 2022	**To**	2 August 2023

Note to DME: Please complete all sections of the report in relation to the last training year. For assistance, please contact Alex McCulloch at alex.mcculloch@nhs.scot or 07908770914.

Please complete and return to alex.mcculloch@nhs.scot by **5.00 pm on the 8th of September 2023.**

1. Year in review: 2022-23

1.1 Please outline the main training achievements in your board in the last training year:

This is the third year of the QI symposium where trainees are invited to submit abstracts and present their QI projects to a hospital wide audience. The standard was very high again this year. The medical director and executive team who were present conveyed their thanks to the trainees for their hard work and commitment to improvement.

A small site survey was completed by the quality team in September of 2022 for our obstetrics and gynaecology department which provided feedback from trainees over a 2-year period. From this, the department were able to work with the trainees to make improvements. The quality visit that followed the NTS survey from 2022 was as a result a constructive and positive experience for everyone involved.

A further small site visit was held in surgery which has led to improvement work resulting in all trainees getting access to clinics. Junior trainees work with the consultant while senior trainees have their own list with consultant support. Operating frequency has also improved as the team is now operating 4 time a week every week with planning 5 times a week from October There are trainee lists – where senior trainees teaches junior trainees to operate on simple hernias with consultant supervision once a month.

A number of new SIM sessions supported by the SIM technician were introduced in several specialities including surgery, Obs and Gynae, anaesthetics and medicine.

An IMG support group was set up by the med Ed department with consultant and trainee input to support IMG during their time at the BGH. We have just received funding via our Training and Education Board to fund an AI programme 'Sim converse' with plan to use for training in patient doctor conversations.

Medical Education has been successful in their bid to fund TRICKLE for a further two years. During this time a further evaluation has been requested with a plan to incorporate into our mainstream approach to staff feedback with future funding incorporated in core budgets. Trickle has given the trainees a platform to raise their voice - and be heard. Over the last year many issues have been raised and addressed including rota concerns, handover, IT issues and accommodation concerns. Trickle has enabled Med Ed to deal with concerns in real time and engage the trainees in solutions as can be seen above with respect to the rotas.

The Big Bash organised by non-training staff for all staff as a welcome to new trainees and a good bye and thank you to those leaving has been a great success again this year. Additionally, the new FY1s starting in August were treated to an Indian buffet to welcome them to NHS Borders.

1.2 Please highlight any sites where you have identified good practice

Site	Details about good practice
	[Please add further lines if required]

1.2 Please outline the main issues that your board has faced in the last training year:

Several speciality rotas struggled throughout the year due to unfilled training posts, early resignations of training and non-training grades, short term sickness absence, LTFT trainees in FT posts and trainees requiring support for training and difficulty access locum cover. NHS borders Med Ed and HR have worked hard with the finance team to secure funding for non-training posts to support rotas to improve the experience for both trainees and non-trainees going forward.

The Obstetric and gyne department as above were struggling to provide a positive training experience for trainees as reflected in the feedback. Working with the trainees following the small site review has had a positive impact as described. The Rota continues to be challenging but the team are working towards solutions.

Similarly, with respect to surgery, trainees had limited access to operating times as elective work was cancelled due to urgent care hospital pressures. Access to clinics were also reduced due to reduction in space allocation. The surgical team have worked with management to address these ongoing concerns and as above access to operating time and clinics have improved.

In medicine access to clinics were also proving difficult due to availability of rooms for trainees. Med Ed worked with trainees and specialities to resolve this with good effect. For the coming year clinic timetable is embedded into the rota to ensure all trainees get appropriate clinic access.

Trainee attendance at teaching locally in medicine had also been poor due to hospital pressures although this time had been protected the trainees didn't feel they could leave the clinical area due to staffing. Teaching has been embedding in the rota and in particular the senior rota has been over established to allow trainees to attend all teaching available.

Trainee moral has been low generally. It has been difficult to engage trainees in forum activity and feedback groups. There has been some support from the wellbeing team in Scottish government to provide hot food appliances for trainees for the sum of £180. We had been offered support to purchase lockers for trainees but unfortunately there was no allocated space for them. We continue to look at alternatives.

Accommodation has been challenging for on call trainees across all specialities. One of the issues related to return of keys and cleaning the rooms in time for the next occupant. In addition, staff had been requesting accommodation and not releasing it if not using it, effectively blocking availability. TRICKLE highlighted these issues and the chief residents with support for Med Ed working with facilities developed a SLWG to help resolve these concerns. As a result, the facilities are controlling access by providing guidance as to who can request

accommodation and improving a key return system to allow access to cleaning. This has highlighted a wider concern in relation to availability of accommodation which has been taken up by the executive team.

Proportionally over the last year compared to others years we have had more trainees struggling requiring additional support and modification of their post at FY and GP level in particular. Some of these trainees were taken off their respective rotas and worked as supernumerary and additional training provided by Sim tech and clinical support.

The Medical Education team has been under staffed in the last year making it difficult for the team to drive initiatives and provide the level of support we normally give in a training Year. We have appointed a band 3 administrator which has been vacant for a year and will start mid-September. The Band 4 administrator is awaiting confirmation of funding before it can be advertised.

1.4 Please outline any new issues that your board is likely to face in the coming training year(s)

Rota's likely to continue to be pressured for the reasons given above.
Accommodation issues continue.
Trainee moral is generally low based on initially feedback at start of rotations in Aug so we have set up a wellbeing group within Chief residents working with AMD and Med Ed to support initiatives.
NHS Borders Med ED team have found small site visits very helpful to support change and there is one currently in progress in GP trainees in medicine.
Limited Med Ed team to support

1.5 Please identify any sites that should be considered for a visit

Site	Reason why a visit may be necessary
	[Please add further lines if required]

2 Postgraduate Medical Education: Quality Report

Key to survey results

Scottish Training Survey (STS)

Key	
R	Low Outlier - well below the national benchmark group average
G	High Outlier – performing well for this indicator
P	Potential Low Outlier - slightly below the national benchmark group average
L	Potential High Outlier - slightly above the national benchmark group average
W	Near Average
▲	Significantly better result than last year**
▼	Significantly worse result than last year**
—	No significant change from last year*
	No data available
	No Data

** A significant change in the mean score is indicated by these arrows rather than a change in outcome.

GMC National Training Survey (NTS)

Key	
R	Result is below the national mean and in the bottom quartile nationally
G	Result is above the national mean and in the top quartile nationally
P	Result is in the bottom quartile but not outside 95% confidence limits of the mean
L	Result is in the top quartile but not outside 95% confidence limits of the mean
W	Results is in the inter-quartile range
▲	Better result than last year
▼	Worse result than last year
—	Same result as last year
	No flag / no result available for last year

No Aggregated data is available this year

- The information used to create the STS Triage lists is from Scotland only. The NTS triage lists are based on UK data.
- If criteria is met from any of the following lists (bottom 2%), they will be noted on the triage list; NTS All Trainee list, NTS Level of trainee list, STS All Trainee List, STS Level of trainee List and NTS Trainer Survey Data List. The criteria used for the triage list are: Number of red flags, significant change in scores, significantly low scores for Specialty, excess triple red flags, aggregated low scores for Specialty and number of aggregated red flags (if applicable).
- If criteria are met from any of the following lists, they will be noted on the High Performers list (top 2%); NTS All Trainee list, NTS Level of trainee list, STS All Trainee list, STS Level of trainee list and NTS Trainer survey data list. The Criterion for the High Performers list are: Triple green flags, significant change in scores, number of green flags, persistent high score, high scores for specialty

- A site can be on both the High Performers and Triage lists because of different scores for the different criterion being in the top or bottom 2%. Two departments with similar results can have different outcomes because of the 2% threshold, as they may be just either side of the threshold meaning one is on the main part of the DME report.
- Please note the number of trainees may not always tally due to the inclusion of programme trainees within the data. For example, Dermatology trainees in a post may actually be part of the Medicine Programme.

2.1 Departments in the bottom 2% for that Specialty

2.1.1 Site: Borders General Hospital - B120H, General psychiatry

Identified by: STS Level Triage list (significant change in scores, significantly low for specialty and number of red flags)

GMC NTS (Trainee)

Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
All Trainee	P	W	W	W	W	W			W	P	P	R		W		P	W	W	3
ST																			<3

Scottish Training Survey

Level	Clinical Supervision	Discrimination	Educational Environment & Teaching	Equality & Inclusivity	Handover	Induction	Team Culture	Wellbeing Support	Workload	Catering Facilities	Rest Facilities	Travel	N
All Trainees	W▼		W	W	W—	W▼	W—	W	W—	W	W	W	7
Core													2
Core													(2 aggregated)
GPST	R▼		R	W	W—	R▼	W▼	W	W—	W	W	W	4
ST													1
ST													(1 aggregated)

GMC Trainer Survey

Specialty	Appraisal	Educational Governance	Handover	Professional development	Resources to Train	Rota Issues	Support for Training	Supportive environment	Time to Train	Response rate
General psychiatry	W	W	W	W	W	W	W	L	W	67%

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?

The rota has been difficult to populate in recent years due to gaps emerging from unfilled posts and less than full time working sickness absence and sparsity of locums available making it difficult to populate the first-on call rota which can present an additional demand to the cohort of trainees. This in turn this can impact the in-hours timetable and the rhythm and support associated with working as part of the MDT.

This has undoubtedly impacted on the trainee overall experience and impacted on the provision of a supportive environment. However, it is important to note that the overall numbers are small and this may exaggerate the overall rating and trends either way. It would be interesting to understand if this represents the experience of one individual and if a small site survey would be of benefit as it has been in other departments.

With respect to induction, there is a standardised timetable of induction which is altered over time depending on trainee feedback. Many of the induction presentations are now recorded for those that can't attend on the specific day. The team will ask for further feedback following the most recent induction to triangulate.

In terms of educational environment and teaching and clinical supervision, this is a concern to the department who try to provide a supportive and tailored educational experience for their trainees. All trainees are offered weekly supervision with a senior doctor, usually the consultant within their team. From that setting, a plan of the trainee's placement is made early on and clinical experience offered taking that and the trainee's competencies into account. No specific concerns have been feedback internally relating to the delivery of weekly clinical supervision to GP trainees or the provision of a suitable educational experience. There are 'junior' representative at their monthly Medical Staffing Committee which is a further means for escalating of any issues to the senior doctors within the service. The team recognise that there have been inconsistencies in the local education and journal club meetings due to staffing pressures.

As part of the overarching medical workforce plan, psychiatry is seeking to increase the number of middle-grade and other non-training grade doctors within the service. It is anticipated that this will mitigate against stretched first-on call cover and promote a more consistent in-hours experience for trainees. There is also a plan for the new Specialty Doctors to take on additional

leadership roles which can include ownership of the local education meetings and formal support to the trainees in addition to that offered by the clinical team. Finally, senior doctors within or service are considering the role of a medical psychotherapist in supporting them and potentially the trainees. As part of this, it could be a Balint group is offered to the junior doctors in the near future.

In summary:

1. A survey of our current trainees regarding the local induction is to be undertaken to ensure any improvements are added for the next changeover
2. The employment of additional non-training grade doctors to reduce the risk of first-on rota gaps and to provide a more rota resilient which will allow for a more consistent in-hours educational experience and sense of support
3. The psychiatry department plan to formalise the relationship and support to the trainees from the newly expanded group of Specialty Doctors to ensure a further layer of support and enhance the educational experience
4. Local leadership will be embedded in the local education and journal club sessions within the service to ensure continuity
5. The service will consider the introduction of a Balint group for trainees

2.2 Departments in the top 2% for that Specialty

2.2.1 Site: Borders General Hospital - B120H, Obstetrics and gynaecology

Identified by: NTS All Trainee High Performers list (significant change in scores and number of green flags), NTS Level High Performers list (significant change in scores and number of green flags) and STS Level High Performers list (number of green flags)

GMC NTS (Trainee)

Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
All Trainee	W▲	W—	G▲	L▲	W—	G▲	G▲	G▲	W▲	W▲	G▲	W—	G▲	G▲	W▼	G▲	G▲	G▲	7
ST	W▲	W—	W—	L▲	W▲	G	G▲	G▲	W▲	W▲	G▲	W—	W▲	G▲	G▲	G▲	G▲	G▲	4
F2																			<3
GPST																			<3

Scottish Training Survey

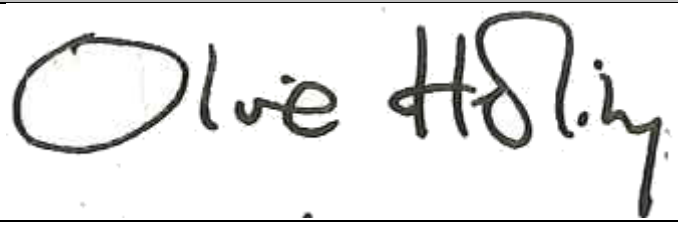
Level	Clinical Supervision	Discrimination	Educational Environment & Teaching	Equality & Inclusivity	Handover	Induction	Team Culture	Wellbeing Support	Workload	Catering Facilities	Rest Facilities	Travel	N
All Trainees	W—	W	G	W	W—	G▲	W▲	W	W—	W	W	W	10
Foundation	W—		G	W	W—	G▲	W—	W	G—	W	W	W	3
GPST	W		W	W	W	W	W	W	W	W	W	W	4
ST	W—	W	W	W	W—	G▲	W—	W	W—	W	G	W	3

GMC Trainer Survey

Specialty	Appraisal	Educational Governance	Handover	Professional development	Resources to Train	Rota Issues	Support for Training	Supportive environment	Time to Train	Response rate
Obstetrics and gynaecology										20%

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?
It is really great to see the return of positive feedback to the department. Last year Survey red flags resulted in a triggered visit. In advance of this visit a small site survey was undertaken by the quality team and this gave further insight into trainee concerns. This enabled the consultant team to work with the trainees to provide a more satisfying training experience which is reflected in this year's survey. The deanery visit was also a positive experience and the consultant body felt enabled and supported by NES Quality team. The education leads comment sums up the feeling of the department 'The small site review which was conducted in the department was exceptionally helpful as it allowed us as a team to address all the areas which were highlighted as a concern. Often a broader stroke review means as a team we lack understanding of where the specific issues lie, making improvement difficult. We were able to immediately make changes to the running of our rota, the teaching sessions, induction and other areas'.

3 Sign-off

Form completed by	Role	Signature	Date
Olive Herlihy	DME NHS Borders		7/9/23

Appendix 1. NTS Data for departments not on Triage/High Performers lists

Site	Programme Group	Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
Borders General Hospital - B120H	Acute Internal Medicine	All Trainee																			<3
Borders General Hospital - B120H	Acute Internal Medicine	ST																			<3
Borders General Hospital - B120H	Addiction Psychiatry	All Trainee																			<3
Borders General Hospital - B120H	Anaesthetics	All Trainee	W—	W—	W—	W—	P▼			P▼	P▼	P▼	W—	R▼	W▼	W—	W—	W▼	L—	W—	4
Borders General Hospital - B120H	Anaesthetics	ST																			<3
Borders General Hospital - B120H	Clinical radiology	All Trainee																			<3
Borders General Hospital - B120H	Clinical radiology	ST																			<3
Borders General Hospital - B120H	Community Child Health	All Trainee																			<3
Borders General Hospital - B120H	Core Anaesthetics	Core																			<3
Borders General Hospital - B120H	CPT	Core																			<3
Borders General Hospital - B120H	Endocrinology and diabetes mellitus	All Trainee																			<3
Borders General Hospital - B120H	General (internal) medicine	All Trainee	W—	W▲	W—	W—	W—	W—	W—	W—	W—	R—	W—	W▲	W▲	W—	W—	W—	W—	W—	13
Borders General Hospital - B120H	Geriatric medicine	All Trainee	W—	W—	W—	W▼	W—	W	W	W▼	W—	W—	W—	W—	W▼	W—	W—	W▼	W▼	W—	7
Borders General Hospital - B120H	Geriatric medicine	ST																			<3
Borders General Hospital - B120H	GP Prog - Medicine	GPST	G▲	W▲	W—	L▲	W—			L▲	W—	W▲	W—	W▲	W—	W—	W—	W—	L▲	W▲	3
Borders General Hospital - B120H	GP Prog - Paediatrics and Child Health	GPST																			<3
Borders General Hospital - B120H	GP Prog - Psychiatry	GPST																			<3
Borders General Hospital - B120H	GP Prog - Surgery	GPST																			<3
Borders General Hospital - B120H	Haematology	All Trainee																			<3

Borders General Hospital - B120H	Internal Medicine Training Stage One	IMT	W—	W—	W—	W▼	W—		W—	W—	W—	W—	W—	G▲	W▼	W—	W—	W▼	P▼	R—	5
Borders General Hospital - B120H	Medicine F1	F1	W—	W▲	W—	W—	W—	W—	W—		W▼		W—		W—	W—	W—		G—	W—	W—	9
Borders General Hospital - B120H	Medicine F2	F2	W	W	W	W	W	W		W	W		P		W	W	G	W	W	W	4
Borders General Hospital - B120H	Paediatrics	All Trainee	W—	W—		L▲	W—	W	W	W—	P▼	W—	W—	W—		W—	W	L▲	L▲	W▼	3
Borders General Hospital - B120H	Paediatrics	ST																			<3
Borders General Hospital - B120H	Surgery F1	F1	W—	W—	G▲	G▲	W—	L▲	W—		W—		W—			L▲		W—	G▲	W—	3
Borders General Hospital - B120H	Surgery F2	F2																			<3
Borders General Hospital - B120H	Trauma and orthopaedic surgery	All Trainee	W—	W—	W—	W▼	P▼	W▼	W▼	P▼	W▼	W▼	W—	W—	W▼	W▼	W—	W—	G—	W▼	5
Borders General Hospital - B120H	Trauma and orthopaedic surgery	ST																			<3
Earlston Medical Practice - 16564	General Practice	All Trainee																			<3
Roxburgh Street Surgery - 16013	General Practice	All Trainee																			<3
Roxburgh Street Surgery - 16013	General Practice F2	F2																			<3
Selkirk Medical Practice - 16085	General Practice	All Trainee																			<3
St Ronan's Practice - 16121	General Practice	All Trainee																			<3
Teviot Medical Practice - 16545	General Practice	All Trainee																			<3
The Neidpath Practice - 16160	General Practice	All Trainee																			<3
The Tweed Practice - 16211	General Practice	All Trainee																			<3

Appendix 2. NTS Trainer Data for departments not on Triage/High Performers lists

Site	Specialty	Appraisal	Educational Governance	Handover	Professional development	Resources to Train	Rota Issues	Support for Training	Supportive environment	Time to Train	Response rate
Borders General Hospital - B120H	Anaesthetics	W	W	W	W	G	W	W	W	G	40%
Borders General Hospital - B120H	Endocrinology and diabetes mellitus										100%
Borders General Hospital - B120H	Gastroenterology										50%
Borders General Hospital - B120H	General (internal) medicine	W	W	R—	P	W	R	P▼	W	P	50%
Borders General Hospital - B120H	Geriatric medicine										33%
Borders General Hospital - B120H	Haematology										100%
Borders General Hospital - B120H	Neurology										100%
Borders General Hospital - B120H	Paediatrics	W	R	W	P	P	R	P	R	P	80%
Borders General Hospital - B120H	Palliative medicine										50%
Borders General Hospital - B120H	Trauma and orthopaedic surgery	W	W	W—	W	W	R	P▲	W	W	57%
Borders General Hospital - B120H	Urology										100%

Appendix 3. STS Data for departments not on Triage/High Performers lists

Site	Specialty	Level	Clinical Supervision	Discrimination	Educational Environment & Teaching	Equality & Inclusivity	Handover	Induction	Team Culture	Wellbeing Support	Workload	Catering Facilities	Rest Facilities	Travel	N
Borders General Hospital	Acute Internal Medicine	All Trainees	W—		W	W	W—	W—	W—	W	W—	W	W	W	4
Borders General Hospital	Acute Internal Medicine	IMT													2
Borders General Hospital	Acute Internal Medicine	IMT	W—				R	P	W—		W—				(5 aggregated)
Borders General Hospital	Acute Internal Medicine	ST													2
Borders General Hospital	Acute Internal Medicine	ST													(2 aggregated)
Borders General Hospital	Anaesthetics	All Trainees	W—		W	W	W—	W—	W—	W	W—	W	W	W	7
Borders General Hospital	Anaesthetics	Core	W▼		W	W	W—	W—	W—	W	W—	W	W	W	4
Borders General Hospital	Anaesthetics	Foundation													1
Borders General Hospital	Anaesthetics	Foundation	W—				W	W	W—		W—				(7 aggregated)
Borders General Hospital	Anaesthetics	ST													2
Borders General Hospital	Anaesthetics	ST	W—				W	W	W—		W—				(7 aggregated)
Borders General Hospital	Cardiology	All Trainees													1
Borders General Hospital	Cardiology	All Trainees	W				W	W	W		W				(3 aggregated)
Borders General Hospital	Cardiology	ST													1
Borders General Hospital	Cardiology	ST													(2 aggregated)
Borders General Hospital	Clinical Radiology	All Trainees	W		W	W		W	W	W	W	W	W	W	3
Borders General Hospital	Clinical Radiology	ST	W		W	W		W	W	W	W	W	W	W	3
Borders General Hospital	Gastroenterology	All Trainees													1
Borders General Hospital	Gastroenterology	All Trainees													(2 aggregated)
Borders General Hospital	Gastroenterology	IMT													1
Borders General Hospital	Gastroenterology	IMT													(2 aggregated)
Borders General Hospital	General (Internal) Medicine	All Trainees	W—	W	W	W	W—	P—	W—	W	R—	W	G	R	37
Borders General Hospital	General (Internal) Medicine	Foundation	W—	W	W	W	W▲	W—	W—	W	P—	W	G	W	26
Borders General Hospital	General (Internal) Medicine	GPST	W—		W	W	W—	W—	W▼	W	W—	W	W	W	6
Borders General Hospital	General (Internal) Medicine	IMT	W		W	W	W	W	W	W	W	W	W	W	3
Borders General Hospital	General (Internal) Medicine	ST													2
Borders General Hospital	General (Internal) Medicine	ST	W—				R	P	W—		G—				(13 aggregated)
Borders General Hospital	Geriatric Medicine	All Trainees	W▲	W	W	W	W▲	W—	W—	W	W▲	W	W	W	15
Borders General Hospital	Geriatric Medicine	Foundation	W—		W	W	W—	W—	W—	W	W—	W	W	W	7
Borders General Hospital	Geriatric Medicine	GPST													2
Borders General Hospital	Geriatric Medicine	GPST	W				L	W	W		W				(3 aggregated)
Borders General Hospital	Geriatric Medicine	IMT	W—		W	W	W▲	W—	W—	W	W—	W	W	W	4
Borders General Hospital	Geriatric Medicine	ST													2
Borders General Hospital	Geriatric Medicine	ST	W—				W	W	W—		W—				(4 aggregated)
Borders General Hospital	Haematology	All Trainees													1
Borders General Hospital	Haematology	All Trainees	W—				W	R	W—		W—				(4 aggregated)
Borders General Hospital	Haematology	Foundation													1
Borders General Hospital	Haematology	Foundation	W—				W	W	W—		W—				(4 aggregated)
Borders General Hospital	Medical Oncology	All Trainees													1

Site	Specialty	Level	Clinical Supervision	Discrimination	Educational Environment & Teaching	Equality & Inclusivity	Handover	Induction	Team Culture	Wellbeing Support	Workload	Catering Facilities	Rest Facilities	Travel	N
Borders General Hospital	Medical Oncology	All Trainees													(2 aggregated)
Borders General Hospital	Medical Oncology	Foundation													1
Borders General Hospital	Medical Oncology	Foundation													(2 aggregated)
Borders General Hospital	Old Age Psychiatry	All Trainees	L—		W	W	W—	W—	L—	W	W—	W	W	W	4
Borders General Hospital	Old Age Psychiatry	Core													1
Borders General Hospital	Old Age Psychiatry	Core	W—				P	W	W—		W—				(4 aggregated)
Borders General Hospital	Old Age Psychiatry	Foundation	W		W	W	P	W	W	W	G	W	G	W	3
Borders General Hospital	Paediatrics	All Trainees	W—	G	W	W	W—	W—	W—	W	W—	W	W	W	10
Borders General Hospital	Paediatrics	GPST	W▼		W	W	W—	W—	W—	W	W—	W	G	W	5
Borders General Hospital	Paediatrics	ST	W—	G	W	W	W—	W—	W—	W	W—	W	W	W	5
Borders General Hospital	Substance Misuse Psychiatry	All Trainees													1
Borders General Hospital	Substance Misuse Psychiatry	All Trainees													(1 aggregated)
Borders General Hospital	Substance Misuse Psychiatry	Core													1
Borders General Hospital	Substance Misuse Psychiatry	Core													(1 aggregated)
Borders General Hospital	Trauma and Orthopaedic Surgery	All Trainees	W▲	W	W	W	W—	W—	W—	W	W—	W	W	W	10
Borders General Hospital	Trauma and Orthopaedic Surgery	Foundation	W—		W	W	W▲	W—	W—	W	W—	W	W	W	4
Borders General Hospital	Trauma and Orthopaedic Surgery	GPST	W▲		W	W	W—	W—	W—	W	W—	W	W	W	6
Coldstream Medical Practice	General Practice	All Trainees													2
Coldstream Medical Practice	General Practice	All Trainees	W				G	W	W		W				(3 aggregated)
Coldstream Medical Practice	General Practice	Foundation													2
Coldstream Medical Practice	General Practice	Foundation													(2 aggregated)
Earlston Medical Practice	General Practice	All Trainees													2
Earlston Medical Practice	General Practice	All Trainees	W—				W	W	W—		W—				(5 aggregated)
Earlston Medical Practice	General Practice	Foundation													1
Earlston Medical Practice	General Practice	Foundation													(1 aggregated)
Earlston Medical Practice	General Practice	GPST													1
Earlston Medical Practice	General Practice	GPST	W—				W	W	W—		W—				(4 aggregated)
Roxburgh Street Surgery	General Practice	All Trainees	W		W	W		W	W	W	W	W	L	W	3
Roxburgh Street Surgery	General Practice	Foundation	W		W	W		W	W	W	W	W	L	W	3
St Ronan's Practice	General Practice	All Trainees													1
St Ronan's Practice	General Practice	All Trainees	W—					W	W—		W—				(3 aggregated)
St Ronan's Practice	General Practice	GPST													1
St Ronan's Practice	General Practice	GPST	W—					W	W—		W—				(3 aggregated)
The Neidpath Practice	General Practice	All Trainees													1
The Neidpath Practice	General Practice	All Trainees													(2 aggregated)
The Neidpath Practice	General Practice	GPST													1
The Neidpath Practice	General Practice	GPST													(2 aggregated)
The Tweed Practice	General Practice	All Trainees													2
The Tweed Practice	General Practice	All Trainees	W—					W	W—		W—				(6 aggregated)
The Tweed Practice	General Practice	GPST													2
The Tweed Practice	General Practice	GPST	W—					W	W—		W—				(6 aggregated)

Appendix No 5 BGH OG Visit

Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	23rd March 2023	**Level(s)**	FY, GP, ST
Type of visit	Triggered	**Hospital**	Borders General Hospital
Specialty(s)	Obstetrics & Gynaecology	**Board**	NHS Borders

Visit panel	
Dr Peter MacDonald	Visit Chair – Associate Postgraduate Dean - Quality
Dr Karine Newlands	Training Programme Director – GP
Dr Martin Carlin	Training Programme Director - Foundation
Dr Chris Lim	Trainee Associate
Richard Gibbons	Lay Representative
Fiona Paterson	Quality Improvement Manager
In attendance	
Gayle Hunter	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Obstetrics, Gynaecology & Paediatrics
Lead Dean/Director	Professor Alan Denison
Quality Lead(s)	Dr Alastair Campbell & Dr Peter MacDonald

Quality Improvement Manager(s)	Fiona Paterson									
Unit/Site Information										
Non-medical staff in attendance										
Trainers in attendance										
Trainees in attendance	7									
Feedback session: Managers in attendance	Chief Executive		DME	x	ADME		Medical Director	x	Other	x

Date report approved by Lead Visitor	

1. Principal issues arising from pre-visit review:

The O&G department at Borders General Hospital was last visited in March 2018, this was a scheduled deanery visit. Overall, this was a positive visit although some concerns were raised around patient boarding. 5 requirements were set and the action plan submitted for review at SQMG and signed off for regular monitoring.

The unit was part of a small site assessment pilot in 2022 which identified areas for improvement, as this was a pilot survey, requirements could not be set however this provided an opportunity for the unit to review and take action prior to the forthcoming visit.

The visit commenced with a detailed presentation from Dr Kate Darlow which provided an update highlighting the improvements made within the department since the pilot survey.

A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

2.1 Induction (R1.13):

Trainers: Following review, departmental induction has been updated to ensure trainees are adequately equipped to start work. Induction comprises a welcome pack, tour of the hospital, presentations and Badgernet training. Advanced Badgernet training is provided once trainees are in post and familiar with the system.

Trainees: All trainees present received induction which prepared them well for their role. System access was provided promptly, some basic Badgernet training was given with a more in depth session planned for later in the post, however trainees told us the charge midwife has delivered informal sessions and there is always someone to seek support from as required. Trainees did not have any suggestions for improvements.

2.2 Formal Teaching (R1.12, 1.16, 1.20)

Trainers: Trainers described a variety of formal teaching opportunities available to trainees, these included.

- Daily departmental case-based discussions,
- Weekly Oncology risk,
- Monthly Perinatal risk,
- CME – Audit and scenarios,

- Obstetrics Risk,
- Cardiotocography,
- PROMPT and
- Simulation

We were told that for cohort-specific teaching trainees provide cover and for sessions held out-with the department the consultants will cover the workload. Teaching sessions are not interruption-free but everyone is aware interruptions should be minimal during this time.

Trainees: GP trainees can attend hospital wide GP teaching every 2nd week, Specialty trainees were able to attend an estimated 70% of their national teaching sessions. SE Regional teaching has been cancelled at short notice and trainees told us these sessions had not been rearranged. What trainees described as national training (pan-Scotland) was considered to be very good and happened as timetabled. Trainees felt it would be beneficial if the regional/national sessions were recorded to allow those unable to attend to watch at a convenient time.
All trainees described a rich informal learning environment with lots of ad hoc teaching. Due to the size of the department opportunities to work closely with consultants in theatre and clinics are abundant.

All trainees noted it would be beneficial to have cohort specific local teaching sessions but acknowledged the challenges due to staffing. Due to the exceptionally high standard of informal teaching provided any formal teaching programme would need to be high value.

2.3 Study Leave (R3.12)

Trainers: Trainers advised that there have been no issues in supporting study leave.

Trainees: Trainees confirmed they have good access to study leave.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

Trainers: All trainers have time recognised within their job plans however some felt that the amount of time allocated was not sufficient to carry out all elements of the role. Any known concerns regarding a trainee would be provided via the TPD and a support plan implemented.

Trainees: All trainees had been allocated educational supervisors, met with them and agreed learning plans. Trainers were described as accessible and intuitive facilitating informal learning.

2.5 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: Trainers felt able to work closely with and learn individual competence levels of trainees. There is a notice board outside labour ward with photographs of all team members which is updated regularly.

After feedback from trainees regarding the accessibility of the on-call consultant, this role now has a dedicated bleep. The on-call consultants are identified at the morning huddle and all consultants carry a pager should they need to be contacted. Any out of hours gynaecological issues are diverted through the switchboard directly to the consultant. The role of Advanced Birth Practitioners (ABP) is detailed at induction and a crib sheet created clarifying which procedures require consultant presence.

Trainees: Trainees advised that they know who to contact during the day and out of hours and do not feel they have to cope with problems beyond their competence. The unpredictable nature of the specialty can sometimes result in a delay for support however, this has been raised with the consultant body and addressed.

2.6 Adequate Experience (opportunities) (R1.15, 1.19, 5.9)

Trainers: We were told that all trainers are aware of the curricular requirements for each cohort, they attend online teaching courses and utilise online resources to ensure they stay up to date with changes. All trainees have improved access clinics relevant to their training. As the impact of the Covid-19 pandemic reduces, theatre experience for specialty trainees has increased with more regular theatre lists throughout the hospital. The birth rate at the unit has dropped below 1000 per year which has a direct impact on obstetric procedures and training, increased simulation sessions have been implemented to address.

Trainees: Trainees described a valuable training placement with proactive nurses, midwives and consultants who help turn activities into learning opportunities. Both GP and ST trainees have good clinic access with GP trainees stating they have a ‘normal’ day built into their rota which facilitates attendance at clinic or theatre sessions relevant to their training. ST’s advised that due to the lower delivery rate there may be some competencies such as the management of complicated deliveries which may not be met in this placement. However, they noted that when on call they have the opportunity, dependent on case presentation, to achieve some more advanced procedures than they might expect at ST3/4 level.
All felt the post offers good exposure to opportunities to manage acutely unwell patients.

2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)

Trainers: Trainers reported that there are plenty of educational opportunities for trainees to achieve their assessments and that they actively encourage submissions.

Trainees: All trainees reported no issues in completing their workplace-based assessments.

2.8 Adequate Experience (multi-professional learning) (R1.17)

Trainers: Trainers advised there are several opportunities for multi-professional learning and trainees regularly work with ABP's, nurses and midwives. Simulation sessions run twice weekly along with regular multidisciplinary teaching days. The obstetrics MDT historically had been a closed forum however this has recently changed to allow trainees to attend.

Trainees: Trainees reported that they participate in lots of interprofessional learning.

2.9 Adequate Experience (quality improvement) (R1.22)

Trainees: Trainees were unaware of a QI lead within the department but felt that support would be provided if requested.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Consultants provide regular constructive informal and formal feedback to trainees. A request from the theatre team to not provide trainee feedback at night was dismissed.

Trainees: Trainees advised they receive constructive and meaningful feedback.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Dr Kate Darlow (college tutor) holds an informal monthly meeting with the trainees which allows concerns to be raised. Trainees are also encouraged to speak directly with Dr Darlow if they do not wish to discuss their concerns publicly.

Trainees: Trainees have autonomy to change identified areas through regular monthly meetings with Dr Darlow. Concerns raised are placed on an action plan and updates discussed until resolution. Trainees were aware of a hospital trainee forum although none had attended. They provided examples of active listening from the consultant body which resulted in positive change.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt they had worked hard to provide a positive, open, and supportive culture within the department. The monthly meeting allows trainees to raise concerns at an early stage allowing them to be dealt with promptly before they become a larger issue. There is a good news board within the unit celebrating positive learning.

Trainees: Trainees stated that they work within a very supportive unit with approachable consultants and wider multi-disciplinary team. None of the trainees had experienced or witnessed bullying or undermining behaviours. If they were to, trainees stated they would raise with Dr Darlow. They told us handover and CTG teaching provides and open forum for healthy debate for both trainees and consultants to learn.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Following feedback from the previous cohort of trainees the middle grade rota was revised with trainees no longer working 48 hour weekend on-call shifts. Weekends are now split with a rest day scheduled after a 24hr on-call shift. Locums are employed to ensure the rota is compliant with all legal requirements. Rotas are managed by trainees and provide an even allocation of theatre and clinical time for all trainees.

Trainees: Trainees told us that their rota is very well balanced and accommodates good access to learning opportunities. They reported that rota gaps are well managed. GP trainees have excellent outpatient experience on their normal days but noted these would be pulled if service required. To further enhance the GP experience, it was suggested some forward planning of clinic attendance would be beneficial. All trainees felt their workload was manageable and when on 24-hour on call shifts they were able to take adequate rest breaks.

2.14 Handover (R1.14)

Trainers: There is a daily multi-disciplinary handover at 08.30, all patients are discussed which provides safe continuity of care. Handover has been further enhanced with the addition of a shared document which details all inpatients, those expected and boarders.

Trainees: Trainees reported that there is a good, structured handover in place which facilitates learning opportunities as each patient is discussed and feedback given on management plans.

2.15 Educational Resources (R1.19)

Trainers: An additional computer has been added to the doctor’s room following trainee feedback.

Trainees: Trainees were happy with the resources available however noted the WIFI can be intermittent at times.

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

Trainees: Trainees told us support was available for those who were struggling and provided examples where reasonable adjustments were made for trainees.

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

Trainees: Any concerns regarding the quality of training would be raised through the monthly meetings with Dr Darlow.

2.18 Raising concerns (R1.1, 2.7)

Trainees: Trainees advised they would raise any concerns with the registrar who would then escalate to consultant level if required. They would also be comfortable raising concerns with the wider obstetrics team. Risk management meetings provide the opportunity to review cases and share learning from incidents.

2.19 Patient safety (R1.2)

Trainers: The reduced birth rate had a potential to deskill the obstetrics team, the trainers acknowledge the need to increase drills/scenario training. At present there is no gynaecology inpatient ward and patients will board on a general surgery ward. There is a service review underway and it is hoped this will address the gynaecology layout.

Trainees: Trainees have no concerns regarding patient safety and are confident any issues would be dealt with appropriately. They echoed the need for a gynaecology space for inpatients but told us that a dedicated room had been created within urgent care to assess patients.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4)

Trainees: Trainees reported using the Datix system to report an adverse incident. These are discussed at M&M meetings and are very well supported within the department. Some trainees felt it would be desirable to have more information following the transfer of a baby to the special care baby units.

2.21 Other

All trainees spoke of the supportiveness of the consultants and how they felt they were invested in providing them with the best possible training opportunities. They work collaboratively with the trainers to drive change have the autonomy to drive changes.

3. Summary

Is a revisit required?	Yes	No	Dependent on outcome of action plan review

POSITVE ASPECTS OF THE VISIT

- Commend the work undertaken by the DME and department to target areas of concern raised in the pilot survey.
- Training is prioritised and desire to maximise all available opportunities.
- Both GP and ST trainees reported a valuable training placement, gaining useful learning and practical experience relevant to their future careers.
- Induction prepares trainees well for their role. Passwords and training for Badgernet and TRAK are adequate and trainees felt supported.
- Lots of informal teaching delivered on a 1 to 1 basis and through handover. Other more formal processes such as simulation and multidisciplinary activity was also positive.

- Concerns regarding clinical supervision have been resolved, the new mechanism of consultant pagers is working well.
- GPST's have good opportunities to attend clinic/theatre sessions.
- The department are proactive in listening to trainee concerns with action and resolution.
- Very proactive college tutor (Kate Darlow).
- Positive culture within the dept across multi-professionals contributing to positive experience for trainees.
- Organised social event at changeover to help create friendly team environment.
- Feedback to trainees was reported as very positive.
- Handover system is working well and further enhanced by suggested improvement from previous trainee.
- Collaborative working between trainers and trainees.
- Positive working relationships across the department, trainees commented on the contribution of the senior charge midwife which helped to create an environment where trainees felt comfortable raising issues with nursing and medical staff.

LESS POSITIVE ASPECTS OF THE VISIT

- Improve formal local teaching for registrar and GP trainees – acknowledge the restrictions with small department.
  Inconsistent Regional/National teaching issue will be raised within the deanery.
- Rota is being organised by trainees which works well at present allowing them to prioritise individual training opportunities, however this could be a future risk. Suggest including an element of consultant oversight to ensure equity is maintained for all individuals.
- It would be beneficial to identify a Quality improvement lead within the department.

4. Areas of Good Practice

Ref	Item	Action
4.1	Feedback	The college tutor has regular meetings with trainees to seek feedback and resolve actions.
4.2	Adequate Experience	The department are proactive ensuring all opportunities are a learning experience.
4.3	Adequate Experience	GP trainees have excellent opportunity to attend outpatient clinics.

4.4	Culture	Trainees feel part of a team which is invested in their training.

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	Adverse Incidents	In relation to adverse incidents one issue mentioned was the fact that sick babies get transferred out of the unit and the team involved in the delivery then don't hear what happened to the infant. Would there be some way of setting up a mechanism for actively obtaining updates on infant progress and feeding this back to the relevant team?

6. Requirements - Issues to be Addressed

Nil

Appendix No 6 DME Enquiries

Scotland Deanery

DME Enquiry

Name	Dr Olive Herlihy
Role	Director of Medical Education
Programme	General Practice

ENQUIRY	
Reference	*GP1*

Following discussion at theGeneral Practice, Occupational Medicine, Public Health and Broad Based Training Quality Review Panel on 04/10/2023it was agreed that further information was required in regard to the following:

Site: Borders General Hospital
Unit/department: Psychiatry
Trainee group:GPST
Issue/concern: Red flags within the STS and negative free text comment re experience

STS TREND 2019-2023							
GPST General Psychiatry	Clinical Supervision	grey	grey	grey	green	red	▼
	Discrimination	yellow	yellow	yellow	yellow	grey	
	Educational Environment & Teaching	yellow	yellow	yellow	yellow	red	
	Equality & Inclusivity	yellow	yellow	yellow	yellow	white	
	Handover	grey	grey	grey	white	white	—
	Induction	grey	grey	grey	white	red	▼
	Team Culture	grey	grey	grey	white	white	▼
	Wellbeing Support	yellow	yellow	yellow	yellow	white	
	Workload	grey	grey	grey	white	white	—
	Catering Facilities	yellow	yellow	yellow	yellow	white	
	Rest Facilities	yellow	yellow	yellow	yellow	white	
	Travel	yellow	yellow	yellow	yellow	white	
	Number of responses	**4**	**1**	**3**	**3**	**4**	

- Didn't have patients to see in clinics for the first two months and this very limited exposure for significant time.

The QRP would like to thank you for your initial response to the data and would be grateful if you could provide an updated response from the department to gpphocqualitymanagement@nes.scot.nhs.ukby 9th February 2024. If you need further clarification of any points mentioned above, or if you'd like to discuss this enquiry, don't hesitate to get in touch:

Quality Improvement Manager: Fiona Paterson
Specialty Group: General Practice, Occupational Medicine, Public Health and Broad Based Training
Email: Fiona.paterson14@nhs.scot

Response

The induction process has been redesigned following trainee feedback, reducing overlap and re-ordering aspects to give priority in key areas. Clinical supervision is embedded within trainee timetables weekly. The education and journal club session is now being overseen by a trainee representative and allows participation across the spectrum of clinical subspecialties. We have embedded a new SD lead for trainee matters which should give further opportunity for trainees to raise and resolve issues affecting their experience early on. There is now collaboration between clinical supervisors in the adult service (where GPSTs are placed) in terms of community outpatient clinic experience which should allow a consistency of exposure to clinical work whilst ensuring individual developmental needs are taken into account.

Please Submit to NES as an Excel File not in PDF Format
Information provided should be from 2022/23

Following feedback, we have split the accountabilty report into two parts (excel and word) for ease of completion by finance and DME teams. Please see information sheet for guidance on completing.

Section	User Information
1a	Tab summaries, initial allocations offered to the Boards and actual funding received, also for sign off by DoF and DME of Boards and date of RAWG approval 1a and 1b are pre-populated by NES based on 22/23 Allocation Letter and Payment on Behalf (POB) payments made to Boards.
2a - Bids	Tab details the bids approved by RAWG and NES in year, including any slippage reflected in payments from NES. NES will prepopulate columns: B, C, D, E, F, I, L Boards should complete G, H, J, K, M, N, O, P etc N – Please provide metric results where available O – Anticipated benefits as per bid details P - please provide brief overview detailing why the anticipated benefit was not achieved for example if the equipment did not fulfil the need.
2b	Tab details of all other spend and slippage of medical ACT in year not either shown in 2a or part opening baseline allocation, i.e. use of additional in year funding not spend on bids as shown on 2a, where the funding has come from- underspend on bid or other health board. All details to be added by Boards
2c	Tab details of baseline recurrent Medical ACT Funding received by Board, include in year recurrent bids per section 1 To allow us to prepopulate this section in future years please complete the excel sheet provided, do not attach as an additional sheet. Please use drop downs where provided. Please apply pay uplift as allocated to spend areas Movement in "Top Sliced" costs should be reflected in section 2c, these would match back to the MOT submissions for 22/23 allocation model. **Staffing time** Medical PA - Consultant/GP PA's Medical WTE - Training grades, Specialty Doctors, CTF's Clinical non medical WTE - all other clinical staff Other WTE - support functions, Admin, Medical ACT officers, education managers ….....
2d	Enter all CTF's or equiviant roles that are within you HB with all or part funding from Medical ACT Please enter as ratio ie 80:20 (ACT:HB)

NHS Scotland Medical ACT 2022/23 Accountability Report

NHS Board: Borders

Section 1 Confirmation of Total Medical ACT Funding Received From NES During 2022/23

a

Confirmation of Allocation of Funding	Recurrent	Non Recurrent*	Total
Base allocation adjusted for regional transfers	£795,937		£795,937
2022/23 Recurrent funding available for recurrent and non recurrent bids.	£0		£0
2022/23 Non recurrent funding available for non recurrent bids only		£15,568	£15,568
2022/23 HCP medicine funding		£15,813	£15,813
Additional Pay uplift	£22,403		£22,403
Initial Allocation Available to Board	**£818,340**	**£31,381**	**£849,720**
Total Funding Available for Bids in 22/23 inlcuding additional Pay uplift and HCP med			**£53,783**

b

Confirmation of Funding Received	Recurrent	Non Recurrent*	Total	
Base Costs	£795,937		£795,937	Detail in section 2c
Bids Approved by RAWG and NES	£22,403	£22,310	£44,712	Detail in section 2a
In year slippage			£0	Detail in section 2a
Total Funding Received	**£818,339**	**£22,310**	**£840,649**	

*Non recurrent spend/bids are for time limited spends usually for 1 financial year but can cover multiple years, examples of multi year spends/bids- Mat leave cover 5 months in year and 7months the year after; capital projects covering several years, IT equipment needed in year; CTF's.

Please refer to word document to sign off

Report Approved at Regional ACT Working Group
Copies can be sent to NES before approved by RAWG

(Y/N)	Date

NHS Scotland Medical ACT 2022/23 Accountability Report

NHS Board: Borders

Section 2a Bids approved by RAWG and NES and funded during 2022/23

	In Year Bid					Slippage			Evaluation Requested				Anticipated Benefits	
Proposal/Item Description	**Recurring (£)**	**Non-Recurring (£)**	**Total (£)**	**Capital (Y/N)**	**Fully Implemented (Y/N)**	**Per POB Payments Schedule (£)**	**Other (details of spend should be included on 2b) (£)**	**Barriers to Full Implementation**	**By NES (Y/N)**	**By Other (Y/N)**	**Report Next Year (Y/N)**	**Detail Results of Evaluation.**	**Achieved (Y/N)**	**Please Provide Details**
Medical Education Administrator		£14,025	£14,025		N	0		Band 3 resigned 2nd Sept 22 so had to employ locum administrator at time and a half for one day per week. Interviews have taken place and appointment offered for full time post funded through ACT						
GP Placement costs for HCP med students- full released Oct 22		£8,288	£8,288		Y	0						Increased costs of B&B accommodation for students in Hawick/Earlston/Galashiels		
Additional Pay uplift	£22,403		£22,403		Y	0						Pay Award funding for ACT staff - not funded by NHSB		
Total	£22,403	£22,312	£44,715	0	0	0	0							
Check to section 1	(0)	3				0								

NHS Scotland Medical ACT 2022/23 Accountability Report

NHS Board: **Borders**

Section 2b	**In Year Spends and Slippage Not Pre- Populated on "Section 2a - Bids" including transfers of funding from other boards**						
Proposal/Item Description		**Board - if using funding transfer from an other board.**	**Recurring (£)**	**Non-Recurring (£)**	**Total (£)**	**Capital (Y/N)**	**Benefits for UG Medical Training (and others where relevant)**
Additional 1% pay uplift			7,315		7,315		
					0		
					0		
					0		
					0		
Total			7,315	0	7,315		

*** Future year spend will need to be approved by RAWG and NES in 22/23 bids process**

NHS Scotland Medical ACT 2022/23 Accountability Report

NHS Board: Borders

Section 2c Recurrent Baseline Medical ACT Funding.

Total per Section 1		796	22		818					
Activity	Provider: Select from Drop Down Menu	2021/22 Cost (£000's)	Movement		2022/23 Cost (£000's)	Reason for Movement (excluding bids)	Staffing time			
			2022/23 Recurrent Bids (£000's)	2022/23 Other (£000's)			Medical PA	Medical WTE	Clinical Non Medical WTE	Others WTE
Band 4 additional support (MedEd Co-ordinator)	Central costs	34			13	Resigned 30/08/2022. Post unfilled from this date.				1
Band 5 additional support (Deputy Medical Education Manager)	Central costs	0			2	Started in post 13/03/2023. Funding from MedEd Co-ordinator vacant post re-used.				1
Band 7 additional support (Medical Education Service Manager)	Central costs	26			26	No change				0.4
DME Salary Costs	Central costs	40			39	No change	2.4	0.24		
ADME Salary costs	Central costs	23			21	No change	1.2	0.12		
GP Placements costs	Primary Care	119			132	ACT Student GP from PACs				
GP Student Accomodation costs	Primary Care?? B&B?	15			20	B&B				
Central support costs for medical student administration (NHS Lothian)	Health Board	27			25					
Covid protective desk & screen	Other	6			0	No costs for 22/23				
(should just be 24h at £79/h for additional consultant teaching - see attached bid) Additonal 24 hours of consultant-led simulation teaching sessions across Anaesthetics; Paediaterics; Senior Medicine and Surgery. Equipment used to extend range of scanarios taught and immersiveness of simulation.	Other	16			2	Equipment spend was a one off only recurring element is 24hr x £79				
Electrical Upgrades to library to support training access	Other	14			0	No costs for 22/23				
Wifi Installation - Paid installation, broadband and content filtering upfront Oct 2021 - Oct 2023 and contract needs to be renewed Oct 2023 for 24m. Have requested a quote which will include extending provision to two additional houses for GP placements. Will need to keep this line.	Other	16			16	2 yrs contract needs to be paid in advance from Oct 23				
Additional 1% pay uplift	Central costs	14			8	Approx 5% Pay award on salaries				
Just Annual maintenance of medical student bikes; purchase of accessories £810 - see bid	Other	3			1	Annual Bike Maintenance agreement				
Band 6 Clinical Librarian 0.8wte					45					0.80
Band 5 Simulation Technician					16	New start Aug 22 - Mar 23				0.60
					0					
					0					
					0					
					0					
					0					
					0					
Total		**353**	**0**	**0**	**366**					
Balance		- 443	- 22	-	- 452					

8100

NHS Scotland Medical ACT 2022/23 Accountability Report

NHS Board: Borders

Section 2d Additional information

Clinical Teaching Fellows or Board equivalent

ACT:Board Ratio	Number of posts	
80:20	10	*example*

NHS Borders

Meeting:	**NHS Borders Board**
Meeting date:	**1 August 2024**
Title:	**Quality & Sustainability of Acute Services**
Responsible Executive/Non-Executive:	**Lynne Huckerby**
Report Author:	**Lynne Huckerby, Interim Director of Acute Services**

1 Purpose

The purpose of this report is to provide an overview of the strategic risk associated with the quality and sustainability of Acute Services by specialty/service area and the key mitigation measures which have been developed as part of the Transformation bundles; specifically Urgent and Unscheduled Care and the Planned Care Programmes of work.

This is presented to the Board for:

- Awareness

This report relates to a:

- Emerging and live issues

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

- Safe
- Effective
- Person Centred

2 Report summary

A key strategic risk for NHS Borders is the scale and size of many of our services causing levels of vulnerability across our small territorial health board. This strategic risk has been graded as very high. This strategic risk highlights that because of our changing population demographic and complexity, and the evolving nature and expectation of healthcare provision this presents a risk which could lead to unviable service provision in certain specialties and specialist groups. This may lead to a risk that those affected specialties and services could compromise the functioning of the Borders General Hospital.

This risk affects several of our services as outlined below:

2.1 Emergency Department
2.2 Cancer
2.3 Urology
2.4 Dermatology
2.5 Neurology
2.6 Diagnostics
2.7 GI and Endoscopy
2.8 Diabetes and Endocrine
2.9 Orthopaedics
2.10 Haematology
2.11 Laboratory Services
2.12 Women's and Children's Services

Across these specialties and departments there is a clear articulation of the issues and challenges faced as well as a route to recovery. The route to recovery and the status of the recovery plan is also described later in the paper.

This paper should give a (limited) level of assurance that the issues are understood and are being addressed. It should be noted that there remains some key choices to be made by the organisation and/or Scottish Government in addressing those challenges outlined. All the vulnerabilities are known to the organisation, and there is either a plan in place, or an upcoming discussion at NHS Board or BET for further clarification and decision about next steps.

2.1 Situation

2.1 2.1.1 Emergency Department (ED)

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 agreement of a care plan. As per National trends, there are wider system issues impacting performance and quality. Since our internal ED workforce review, high levels of bed occupancy have remained which has impacted length of stay, occupied bed days and delayed discharges. This has significantly increased the time spent waiting for an inpatient (IP) bed in the ED, and has resulted in several instances of overcrowding in the department which is a higher risk to patient safety.

The ED workforce review commissioned by the Medical Director and the substantive Director of Acute Services concluded in April 2023. The three key themes arising from the review were:

2.1.1.1 Additional Medical Cover (overnight).

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 handed senior decision maker in ED.

2.1.1.2 Skill Mix

A lack of appropriate levels of multi-disciplinary team working across Medical and Nursing professional groups. For Nursing, workforce numbers have not been formally appraised and considered since pre-pandemic (prior to March 2020) and are dated. Currently there is a lack of senior nursing cover in the overnight period which also impacts safety and decision making.

2.1.1.3 Clinical Risk(s) – derived from above.

This was supported in principle by the NHS Borders Board in December 2023, subject to confirmation of the financial funding route. In May 2024, BET revisited the review following limited route for funding in the short term through transformation avenues.

2.1.1.4 National Benchmarking

Scottish Government are currently analysing a national benchmarking review on ED staffing profiles which was carried out for week of the 10th June 2024. The result of this exercise is anticipated will be returned by the end of July 2024.

Our own analysis suggests the following benchmarking status:

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**	**2.2**	**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

A decision on investment in ED is being taken to the NHS Borders Board meeting on 1st August.

2.1.2 **Cancer**

It is predicted that there will be an ongoing annual increase of 1-2% in the number of people in the Borders who are diagnosed with cancer each year; by 2030 this will equate to a cumulative increase of 11% compared to the current rates.

In parallel with this, the availability of new treatments and improving outcomes are predicted to see an annual increase of up to 9% in the number of treatment episodes required; by 2030 this will equate to a cumulative increase of 80%.

Changes in the ways that treatments are delivered mean that the rates of increase in nursing and treatment chair time to support delivery of these treatments are projected to be lower than this, but still substantial; it is estimated that by 2030 nursing time required to support treatment will increase by 50%, and chair time to give treatment by 44%.

The growth in demand and treatments for cancer services generates a number of key issues, namely:

2.1.2.1 ***Clinical Leadership***: the SACT medical lead role is currently being provided on a short term basis by NHS Lothian as a result of vacancies in our local haematology service and our Clinical Lead for cancer is due to retire in 2025.

2.1.2.2 ***SACT Treatment***: growth in activity and complexity driven by the availability of new treatments and improving outcomes requires urgent attention. New SACT drugs and treatments are prescribed regionally.

2.1.2.3 ***Medical Input***: because of the increase in SACT treatment and to continue to provide safe service provision, it is deemed there is a requirement for a Specialty Doctor level to provide on-site medical cover.

2.1.2.4 ***Nursing staff.*** The SCAN SACT Workforce Planning tool has been used to demonstrate the current staffing requirement, and likely future changes based on a growth of cancer patients at 8-12% nationally (our local growth rate is in line with this). Additional requirements will include training time, managing growth in activity and expected turnover. A national programme of work is being undertaken to review SACT staff nurse job descriptions which may see an increase in post banding from 5 to 6, the output of which is unknown at this stage.

2.1.2.5 ***Pharmacy staff***. The need for increased support for the preparation of aseptic drugs to meet current levels of demand as well as clinical pharmacist staff to

support other aspects of the SACT treatment pathway, including prescribing and dispensing of drugs.

2.2.2.6 ***SACT Treatment Chair Time***. Current expansion works in BMC will increase the number of treatment chair from 9 to 12 which is predicted will provide sufficient capacity to 2027-28. Thereafter a limitation to the provision of treatment.

2.2.2.7 ***Acute Oncology***. This element of the service responds to the emergency needs of cancer patients, and focuses on the management of patients with complications of their cancer diagnosis and treatment. An interim funding model is in place, but longer-term funding is required to ensure service sustainability.

2.2.2.8 ***Cancer Nurse Specialists (CNS)***. The CNS workforce model is linked to expected cancer incidence, and given the increased growth in demand the line management arrangement is becoming untenable, and a revised management structure is recommended.

2.1.3 **Urology**

There are significant issues with the current way in which consultant support is being delivered to the Urology Service which is via a Service Level Agreement with NHS Lothian. This has been in place for many years; a total of 11 sessions which has in recent years been delivered by 4 consultants.

This service model has been challenging and issues include:

- Weeks when there is no consultant urologist in NHS Borders, service responsibility falls to Associate Specialist trying to balance elective and unscheduled care demand
- No clinical leadership
- No clinical ownership
- Limited clinical supervision for specialist nurses
- Limited consistent medical cover and support

In addition to these challenges the service has extended waits for new outpatient appointments, review appointments and diagnostic investigations.

NHS Borders recently approved the case to employ a permanent consultant to address these issues. It was also acknowledged and supported that the service should retain close link with NHS Lothian to provide the service with resilience. A total of 15.35 sessions were supported. This will provide additional capacity and activity but also support:

- Validating waiting lists
- Apply demand management principles into the service
- Greater productivity through clinics working alongside specialist nurses
- Greater productivity of specialist nurses with close clinical supervision and training

The service is currently in the process of recruitment.

2.1.4 **Dermatology**

Dermatology in NHS Borders has a considerable shortfall in medical staff. Current capacity does not meet demand, which has resulted in excessive waits for assessment and treatment. There is a national workforce shortfall of consultant dermatologists. Locally there has been a longstanding problem to recruit to a consultant dermatologist; this has become more acute over the last 18 months with a long-term locum, GP with Specialist Interest and our only substantive consultant leaving the service.

Dermatology is a high volume service, receiving approximately 2400 new out-patient per year. Capacity is currently being delivered by a combination of locums and capacity commissioned from the independent sector. More recently this has been supplemented through capacity from the National Elective Co-ordination Unit. The service has also engaged with Synaptik and a technology company (Dermicus) to pilot a new innovative approach for assessing skin lesions using a tele-dermatology service. The impact of this included increased capacity, providing reliable clinical prioritisation assessment, streamlining of the care pathway and improved access for patients, however, it is highlighted the need for robust treatment capacity and follow-up.

With continued national workforce issues, the service continues to have no consistent medical cover, clinical leadership or clinical supervision. The service is working hard to try and mitigate the highest risks where possible; these include:

- Risk - delay to seeing all clinical categories of patients – urgent suspicion of cancer, urgent and routine
  Mitigation – continued with capacity as described above
- Risk – no acute emergency service
  Mitigation - locum capacity and virtual dermatology advice service
- Risk - workforce vulnerability
  Mitigation - continued access to locum capacity and independent capacity whilst advertising for substantive consultant and putting new model of care in place
- Risk - financial – cost of current service exceeds budget and allocation of waiting times funding.
  Mitigation – it will continue to be a high cost service until future model and recruitment in place.

The status of Dermatology in NHS Borders has been escalated through Medical directors nationally, and to the Chief Operating Officer in Scottish Government with no support for our local service.

The service will continue to deliver a level of service which will be defined when Waiting Times Plan is agreed, or NHS Borders agree to financially mitigate the clinical risk.

2.1.5 **Neurology**

NHS Borders Neurology Service is predominately an acute based outpatient service that manages the adult age population of the Scottish Borders who have been diagnosed or who are diagnosed with a neurological condition.

The current service model has been in place for a number of years and continues to face significant challenges. These are primarily associated with sustainability and resilience of the current workforce, inability to recruit to specialist posts; specifically, Parkinsons, MS and Epilepsy and associated workload.

NHS Borders has a dedicated ***Parkinsons nurse specialist post***, because of population growth and an increasingly ageing population, the estimated prevalence and incidence of Parkinson's in the UK is expected to rise by around 18% between 2018 and 2025 (Parkinson's UK results from the Clinical Practice Research Datalink Summary Report).

NHS Borders also has a dedicated ***Trainee MS nurse specialist post***, in 2020 Public Health Scotland released MS Prevalence Data that suggested that in Scotland there are around 15,750 people living with MS or 290 per 100,000 population. This equates to 334 people living in the Scottish Borders with MS based on our population of 115,270.

NHS Borders ***does not have a dedicated Epilepsy nurse specialist post*** however it is estimated 1 in 100 people have active epilepsy (source ISD Scotland) - at June 2019 Scottish Borders had a population of 115,510 putting an estimated figure of 1155 on the number of people living in the borders with Epilepsy. The postholder will be reducing their working hours to part-time in August 2024.

The review outlines the levels of activity associated with each of the specialist posts, benchmarking information, demand and capacity analysis, and a GAP analysis against national and regional standards. This staffing deficit has been on the NHS Borders risk register for a number of years.

This review will progress to BET in August for a discussion around the options and next steps.

2.1.6 **Diagnostics**

Increased activity particularly in the out of hours period is making the retention and sustainability of our radiologist and radiographer workforce challenging.

Work is underway to improve the attractiveness of these roles, e.g. shortening the out of hours period for radiologists, however this does not guarantee that we will be able to recruit to our currently vacant posts.

For radiographers we still run an on call system and as workload increases this is becoming unmanageable. The move to a shift system is one option to deal with the increased workload. However, this would require an increase in radiographic staff to deliver this model and therefore a financial investment.

As demand for CT and MRI increases, our infrastructure may not be sufficient to deal with the increasing activity and an increasing in scanning ability may be required. Over the past few years SG have provided funding for mobile scanning and this has allowed us to manage demand, however, should this funding cease, NHS Borders will not be able to continue to deliver the service without reviewing the supporting infrastructure.

2.1.7 **GI and Endoscopy**

In our GI Service we have long waits for new out-patient and return out-patient appointments.

Capacity has been reduced in recent months due to the successful appointment of our GI consultant to the role of Associate Medical Director (Unscheduled Care). In 2023 the fixed term role of the GI Dietician was not continued; therefore, the caseload was returned to the Consultants.

We increased the capacity of the GI Nursing workforce and administrator role permanently in May 2023

The service ensures all vetting and outcoming are completed on the Trakcare system as well as the amalgamation of the nursing waiting lists is an example of some of the improvement activity which has been undertaken. In addition, clinic templates have been amended to include one long waiting patient to help address the backlog. This is monitored via the six weekly GI Out-Patient meetings.

Whilst these activities go some way to addressing the challenges there remains a backlog of review patients, impacted by the reduction in Consultant capacity and the workload from the Dietician coming back to the Consultants. Furthermore, the remaining two GI consultants' time is shared across GI and Endoscopy services. The review patient activity is not reported to SG and therefore limited national awareness of the challenges.

In our Endoscopy service, and again because of the reduced scoping capacity (linked to the successful AMD appointment) key live challenges relate to six week cancer breaches, booking process issues, decontamination and nurse staffing model.

Key actions being taken to address are outlined below:

- Nurse Endoscopist training post funded recurrently, and trainee will be fully trained by September 2024.
- SCN post filled by GI Nurse Specialist who contributes 0.5 WTE to clinical activities.
- Maternity cover in place May 2023 to 2025 to increase clinical cover
- 2024 1 WTE Nurse Colonoscopist funded and advertised – 1 candidate to be interviewed mid-July.
- Extensive work with Medical Records to develop booking SOP to support staff
- Weekly Endoscopy meetings to look at processes/breaches etc
- 6 weekly Endoscopy meeting with the National Lead
- Review of nurse staffing underway
- Following the transfer of nasal scopes from ENT additional support from community supported the decontamination process because of periods of extensive sickness
- New process developed with front desk / service and Cancer Team to alleviate risk of breaches

2.1.7 **Diabetes and Endocrine**

The Diabetes and Endocrinology Service is currently under significant pressure. Current issues are long standing, historical, and have been in situ over the last 8 to 10 years. These issues have been exacerbated by staffing/workforce issues.

As an interim measure to support the Diabetic Nursing Team, a Band 6 fixed term post was recruited to for 18 months. There is also increased training activity within the Diabetes Specialist Nurse (DSN) Team.

Review patient appointments were amended during Covid to try and manage demand. Reviews are now appointed a one-year review, rather than six monthly. However, this year date is regularly missed and can move into more than eighteen months to two years. In-between Consultant reviews, the patients are asked to contact DSN via the helpline, which is only moving the risk, not mitigating. Between appointments, there is significant pressure on the DSNs. Business Intelligence shows that there are 1851 patients on the Diabetic review waiting list with recall dates dating back to 2020.

There continues to be ongoing media / political and patient enquiries regarding pumps and closed loop technology. Due to historic funding not being recurrent, the Board now faces an ongoing cost pressure.

Actions Taken:

- Previous Band 7 is carrying out 1 pump clinic per month
- Advert for Band 7 post has been sent to HR – awaiting advertisement
- New Consultant starts mid-August 0.6WTE

Service Team are developing new local processes and database to manage the current service model as safely and effectively as possible.

Scottish Government have announced £8.8m funding is being made available in 2024/25 to expand access to diabetes technologies. The vast majority of this funding will be used on new kit, but will also cover the costs of the national onboarding team based at the Centre for Sustainable Delivery (CfSD) to ensure there is additional capacity for delivery. New funding is not allocated to NHS Boards at this stage, but will be held centrally and allocated based on patient need.

2.1.8 **Orthopaedics**

Orthopaedics is a high volume specialty receiving approximately 2300 new referrals per year as well as delivering a trauma service to the Borders population. Conversion to surgery benchmarks reasonably well with other Boards.

The main challenge for our local orthopaedic service is access to protected elective inpatient beds for the highest volume procedures – hip and knee arthroplasty. This challenge is due to the service being unable to consistently protect the number of elective beds required to meet demand due to the level of unscheduled care demand and activity within the hospital.

This situation has not only impacted on patients as they are waiting extensive periods of time for their operation (longest waiting patient is currently 84 weeks) but on patient safety and our consultant workforce. A recent National Peer Review noted that all our orthopaedic surgeons were identified as Low Volume Arthroplasty consultants due to current numbers of cases undertaken. There is a significant clinical risk from low volume arthroplasty. Our local consultants have also this raised concern and highlighted our vulnerability in terms of consultant recruitment and retention.

It should be noted that the vulnerability of the consultant workforce in orthopaedics would impact on the whole system from the perspective of viability of emergency rotas and our local emergency department.

Having dedicated bed base will reduce patients waiting times, patient infection, shorter length of stay, fewer cancellations and support increased and consistent operating for surgeons mitigating recruitment and retention issues.

Action currently being progressed to improve access to elective inpatient capacity for hip and knee arthroplasty include:

- Ring fence elective bay in ward 9 (implemented end May 2024)
- Open Ward 17 to short stay procedure releasing additional capacity in ward 9 (Oct 2024)
- Rationalisation of consultants undertaking arthroplasty to increase numbers deliver by each consultant
- Whole system project progressing on reducing delays within the acute hospital

2.1.9 **Haematology**

A service review carried out 2021/22 agreed that the workforce requirements were 2.23 WTE Consultants and 2 WTE ANP. Currently in post there is 1.2 WTE locum consultant, 1 WTE ANP and 1 WTE trainee NP.

We receive all haematology referrals, with complex cases referred to tertiary care (NHS GGC or NHS Lothian) thereafter patients return to our care in NHS Borders for ongoing monitoring until stable.

We provide Chemotherapy in BMC supported by the haematology service and advanced pharmacy prescribers.

The haematology service has been at risk due to the inability to attract and recruit permanent Haematology consultants, over many years. The permanent consultant left in May 2023, and this has left one long term locum Haematologist running the service.

Key actions:

- Following multiple attempts to recruit we have successfully appointed a permanent Consultant starting in September 2024
- We are supporting the NHS locum through CESR certification with support from the NHS Lothian consultant
- Appointed 2nd trainee NP whom we are supporting through advanced practice.
- Honorary contract with CSN in Haematology, NHS Lothian who carries out a virtual outpatient clinic for high-volume patients who require monitoring
- Reviewed outpatient activity prioritising urgent referrals as they are high risk of suspected cancers - monitoring through waiting times forums
- Review of operational processes and streamlining to release clinical time and administration support for clinics
- Communication to GP practices through PACS weekly newsletter on situation and reminder of how to refer to the service
- Shared care with Physicians when there is only 1 consultant available with agreement with NHS Lothian for support for complex patients when required
- Interim arrangements for SACT (systemic Anti-cancer Therapy) clinical lead through oncology service this will be reviewed when permanent Haematology consultant is in post

When the new consultant starts and with current NHS Locum completing CESR we will return to full complement of consultant cover.

2.1.10 **Laboratory Services**

Our lab team are currently supporting the LIMS Programme implementation, which has not been without challenge. The team are continuing to deliver a 24/7 service model as well as provide commitment to significant levels of UAT testing across each of the domains (Microbiology, BHI and BT). The project has failed to meet four go live dates because of limitations around dedicated time commitment to progress testing at a pace consistent with a 2024 delivery date. We have Board level commitment to address the issues and we are confident we can go live with the new Winpath solution before the end of December 2024.

This programme of work has highlighted the vulnerabilities of the service, specifically in relation to the workforce model. It is our intention to undertake a service review at our earliest opportunity.

2.1.11 **Women's & Children's Services**

The Women's and Children's workforce was concluded and approved in December 2023. Women's services within NHS Borders provides care and support throughout the duration of Pregnancy, birth and post-natal care. The service also provides Gynaecological care and Treatment for all women in the Scottish Borders.

Children's services provides care and treatment from birth until the child's 16th birthday unless there are complex needs, the service will support the young person up to the age of 18 years. The Special Care Baby Unit (SCBU) is available for babies who require additional Support and where appropriate shared care from SCBU/Midwifery staff can be provided within the postnatal ward to ensure Mother and Baby remain together.

The review considered a range of factors including workforce, performance and quality standards, benchmarking data, demand and capacity analysis for each of the services in scope, and excluding community paediatric services and out of area care.

The recommendations in the review were accepted and released 2% of the recurring budget (circa £200K). The service is currently implementing the recommendations of the Workforce Review and progressing the next phase of the of the review, which is to review the current medical workforce models, which may result in further release. A review of paediatrics services has commenced, and a data capture exercise is underway.

2.2 Background

2.2.1 The relevance of local and national policies, standards and performance information has been captured as part of the narrative in section 2.1 by specialty/service area.

2.3 Assessment

2.3.1 The current position for each of the specialties/services has been captured above. Key areas of organisational risk relate to:

2.3.1.1 ***Specialist resources*** and our ability to attract to NHS Borders and retain.

2.3.1.2 ***Current Workforce*** and their wellbeing. Many individuals are a 'single point of failure' with no capacity for resilience built into the service model.

2.3.1.3 ***Financial investment*** at a time when the organisation is operating within a financial deficit.

2.3.1.4 ***Reputation*** with the local Border population should services cease and/or be delivered regionally or nationally.

2.3.2 Quality/ Patient Care

This paper highlights the need for a structured approach to addressing the vulnerability of our services, and this will be agreed through Acute Quad. Some of the specialties and services highlighted are the focus of our Urgent & Unscheduled Care Programme Board, and Planned Care Board for 2024/25.

A number of initiatives have been progressed with the support of Clinical Governance colleagues, namely;

2.3.1 ***Emergency Department***: a recent SBAR has been shared with ED colleagues regarding the design and delivery of an implementation programme for patients in ED with extended waits.

2.3.2 ***Adverse Events***: an infographic has been developed and shared across Unscheduled and Planned Care teams designed to improve the process of providing evidence to every SAER.

2.3.3 ***Care Assurance visits***: a plan is in place to reset our local leadership walk rounds which will involve a more quality management structured approach. This is currently being tested and when finalised will be led by the CNM and SCN.

2.3.3 Workforce

As outlined above by specialty.

2.3.4 Financial

The financial implications are articulated in the earlier narrative by specialty.

2.3.5 Risk Assessment/Management

These are described for each of the specialties/service areas. The strategic risk has been updated to reflect the key actions by which we will reduce the level of risk which include the following:

2.3.5.1 A high level strategic action plan addressing all 12 vulnerable services
2.3.5.2 Develop a BGH strategic vision as part of the development of the overarching Organisational/Clinical Strategy
2.3.5.3 Application of the DCAQ methodology to understand population need
2.3.5.4 Implementation of actions to reduce level of risk

2.3.6 Equality and Diversity, including health inequalities

An EDIA workshop is being held late July to initiate EDIAs for all services in scope of our Urgent & Unscheduled Care and Planned Care Programmes of work.

For all other areas, these will be developed following agreement of the strategic direction.

2.3.7 Climate Change

In general terms a positive impact in relation to the services outlined above can be quantified in due course. All the service reviews outlined above should result in less unnecessary attendances. Digital options for service delivery are considered as part of both our Urgent & Unscheduled Care Programme Board and Planned Care Programme Board.

2.3.8 Communication, involvement, engagement and consultation

The level of engagement has been relevant and appropriate for the issues and challenges being addressed. For example, the ED Workforce review has been discussed and agreed (in principle) at NHS Borders Board in December 2023, a further update and set of recommendations will be tabled at the August 2024 Board meeting. In addition, the Cancer Workforce Review will be presented at the Board Development session in August. The Women's and Children's Review was approved at QSB in December 2023. All other specialty challenges have been raised as part of CMT structure and Acute Services Quad.

2.4 Recommendation

NHS Borders Board is asked to note this paper as an update to the strategic risk relating to the Quality & Sustainability or Acute Services. This paper was presented to the July Clinical Governance Committee and have approved the recommendation to create an over-arching risk assessment and associated actions as set out in section 2.3.5 and in accordance with the timelines set as part of the management and mitigation of the strategic risk.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 August 2024**
Title:	**NHS Borders Performance Scorecard June 2024**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Authors:	**Katy George, Planning & Performance Officer Stacy Miller, Business Intelligence Analyst**

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):

- Safe
- Effective

2 Report summary

2.1 Situation

The main body of the scorecard sets out performance as at end of June 2024 against the targets from the Annual Delivery Plan (ADP). The report also includes as appendices performance as noted against some previous Annual Operation Plan/Local Delivery Plan 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 ADP.

In July 2024, a new approach to quarterly monitoring of progress against plans for 2024/25 was issued by Scottish Government to Health Boards. Boards were requested to share a copy of their own local Delivery Plan progress or performance report which they present to their own Board to inform them on progress on delivery against their plans. The intention is that this will provide assurance around delivery in a way which ensures that the Scottish Government is receiving information consistent with that received by the Board itself, whilst also reducing workload and duplication of reporting. In light of this request, it has been proposed that we will submit a copy of this performance report to Scottish Government on a quarterly basis throughout 2024/25.

2.3 Assessment

We are still unable to meet certain trajectory targets however summaries for each of these can be found within the scorecard where available updates have been added.

Where services have been able to provide it, narrative is contained within the body of the scorecard, focusing on waiting times trajectories and the 'hot topics' of emergency access standard and delayed discharges.

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 2024/25 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.

2.3.8 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

- **Awareness** – To note Board performance as at the end of June 2024.

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Moderate Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

PERFORMANCE SCORECARD

As at 30 June 2024

Month 3

Contents

Introduction

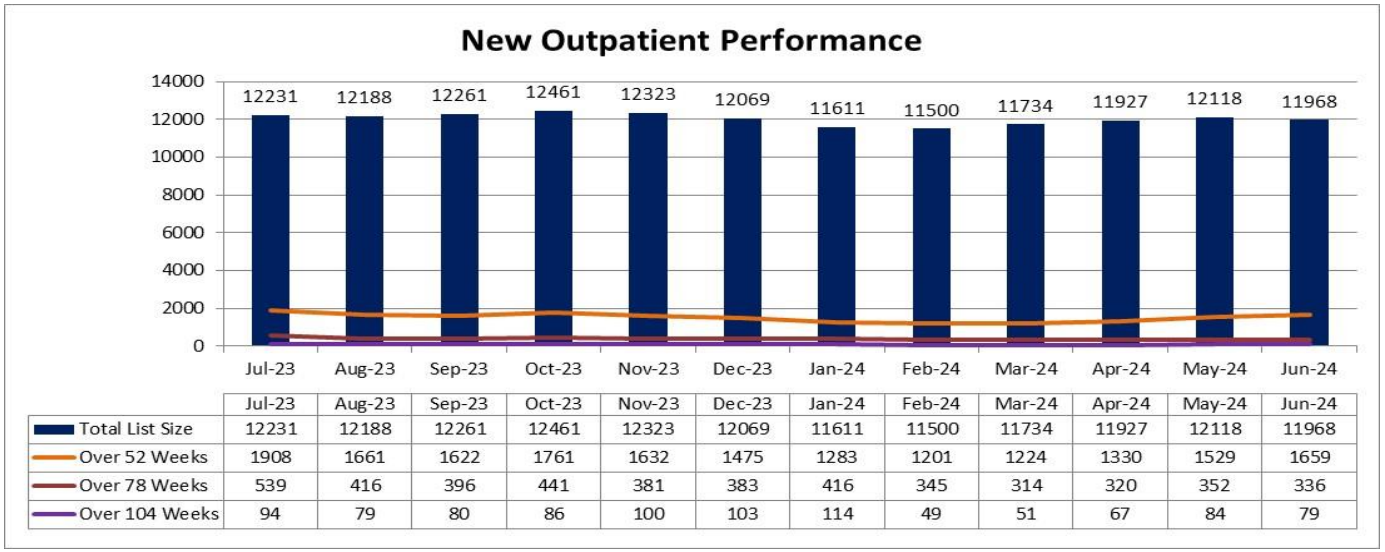
As a result of the COVID-19 Pandemic the 2021/22 Annual Operational Plan (AOP) was replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, the latest iteration being RMP4. In 2022/23 Scottish Government moved away from further remobilisation plans and instead commissioned a one-year Annual Delivery Plan (ADP) aimed at stabilising the system.

This report contains 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 July 2024, a new approach to quarterly monitoring of progress against plans for 2024/25 was issued by Scottish Government to Health Boards. Boards were requested to share a copy of their own local Delivery Plan progress or performance report which they present to their own Board to inform them on progress on delivery against their plans. The intention is that this will provide assurance around delivery in a way which ensures that the Scottish Government is receiving information consistent with that received by the Board itself, whilst also reducing workload and duplication of reporting. In light of this request, it has been proposed that we will submit a copy of this performance report to Scottish Government on a quarterly basis throughout 2024/25.

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).

Outpatients waiting times



	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Total List Size	12231	12188	12261	12461	12323	12069	11611	11500	11734	11927	12118	11968
Over 52 Weeks	1908	1661	1622	1761	1632	1475	1283	1201	1224	1330	1529	1659
Over 78 Weeks	539	416	396	441	381	383	416	345	314	320	352	336
Over 104 Weeks	94	79	80	86	100	103	114	49	51	67	84	79

Figure 1

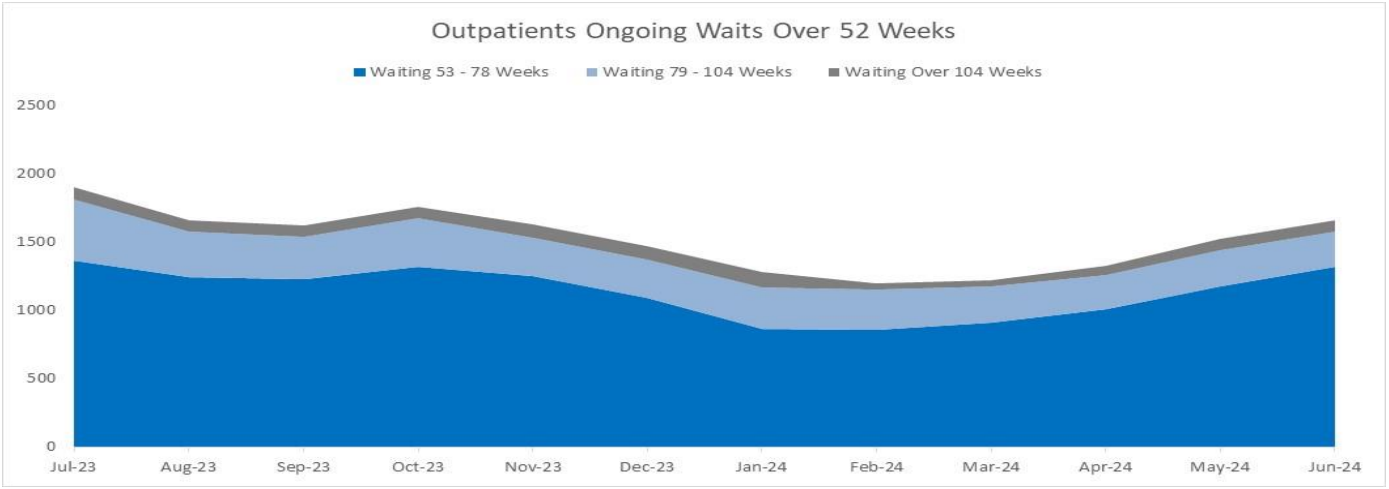


Figure 2

Performance

- New outpatient waiting list size showing limited signs of improvement with currently 11968 patients on the waiting list (Figures 1)
- Number of patients waiting over 52 weeks has continued to rise since January 2024 (Figure 2)

Issues

There are 3 main contributing factors impacting on outpatient performance:

1) Service recovered to 80% of 2019 activity
2) Majority of activity is being clinically prioritised to "urgent" patient referrals resulting is limited capacity to see the long waiting patients
3) Majority of long waiting patients are in specialties with workforce issues

Priorities / Work Plan

Workforce

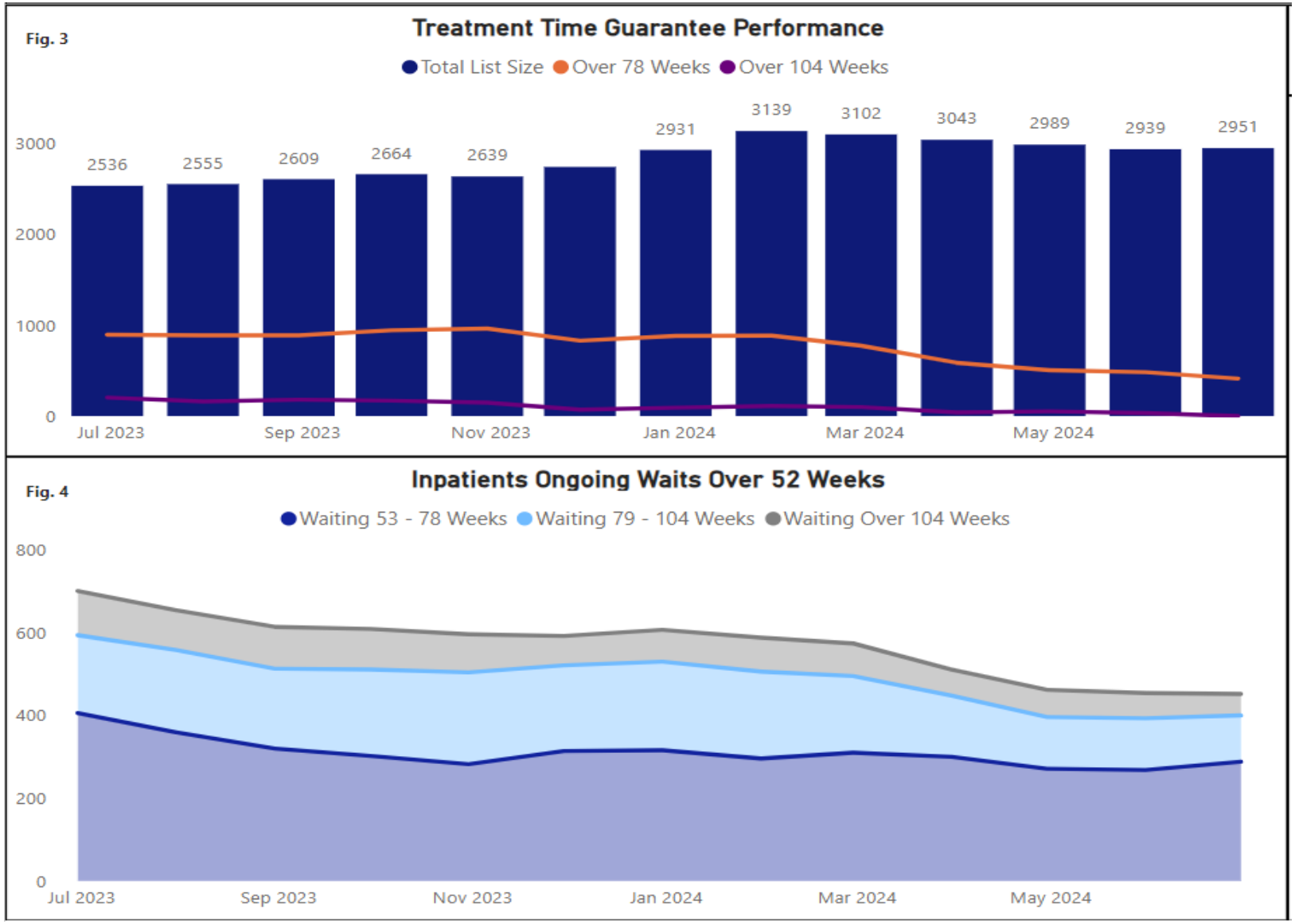
- ENT successfully recruited Specialty Doctor
- Dermatology advertised with no applicants (will be readvertised in 3 months)
- Urology advertised with 2 applicants who have since withdrawn – discussion scheduled that will include NHS Lothian
- Ophthalmologist – interviewed and offer placed.

Service & Process

- Dermatology demand and capacity for next 6 months currently underway – for completion end July. Service being delivered with the support of Tele-dermatology and locum services.
- OPD room capacity implemented and new software live. Some early issues which are being addressed.
- OPD booking post out to advert
- ACRT, PIR and Opt In – recent benchmarking data received for services to assess performance. Local balancing measures will be developed to fully understand our system to focus improvement efforts.
- NECU validation for Dermatology OPD underway (July)
- NECU validation for Urology to be requested (July for completion August)
- Additional weekend clinics to be sourced for Urology (August)
- Bids submitted to SG for ENT and Ophthalmology for additional activity

Updated 25.07.24

TTG Performance Against Trajectory- All Specialties



Performance.

- The size of the IPWL has fallen for the 5th month in a row, assisted by lower-than-average additions from the OPWL (380 in June compared to a yearly average of 431).
- Elective Surgery Activity levels in June were at 81% of 2019 levels, a fall from 91% in May. The lower performance in June was due to 11 cancelled elective lists as a result of a number of staffing issues; 8 were cancelled due to no surgeon (6 x Ophthalmology, 2 x General Surgery), 1 due to no anaesthetist (1 x Orthopaedic) and 2 due to no theatre staff (2 x Orthopaedic). If all had gone ahead this would have resulted in around 40 additional cases (34 Ophthalmology patients, 3 General Surgery and 3 Orthopaedic patients) and activity at 91% of 2019 levels.

Progress.

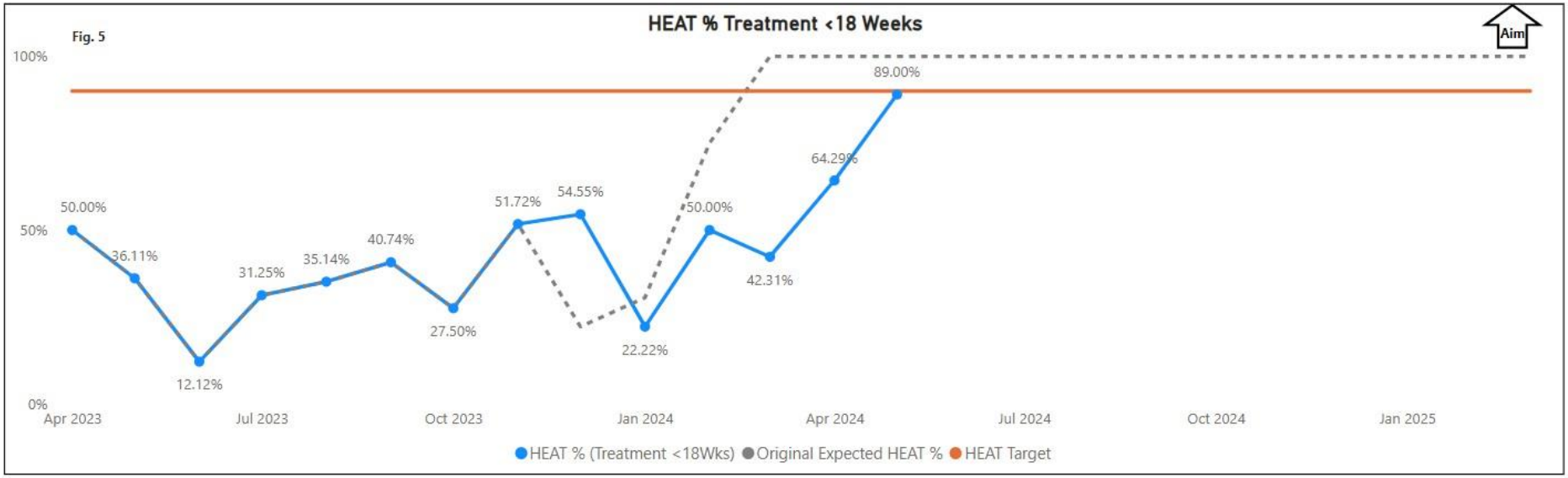
- **B4 and B5 Inpatients Team Central Bookings Office.** Both posts now approved for 18-month extension to Secondments until 1 Jan 2026. These posts are critical to the efficient scheduling of our Operating Theatres and also, from June, of our Pre-Assessment Clinics.

Priorities.

- **Theatre Scheduling - Infix.** Progress Infix through NHSB processes to ensure that it is adopted within our Central Bookings Team to schedule operations. This proposal is due to go to the Digital Prioritisation Board in July for approval.
- **Anaesthetic Staffing.** Support to CD Anaesthetics to resolve unexpected anaesthetic staffing issues that have manifested in July. This has resulted in significant strain on our workforce to cover gaps in rotas and has resulted in a number of Pre-Assessment Clinics and Lists within our Operating Theatres having to be cancelled.
- **SG funding for Elective activity.** Once the template has been received from SG, submit a bid against the £70M fund available from SG to reduce our elective waiting lists. This is likely to focus on securing funding to conduct additional theatre lists within DPU.

Updated 22.07.24

Mental Health Waiting Times – CAMHS



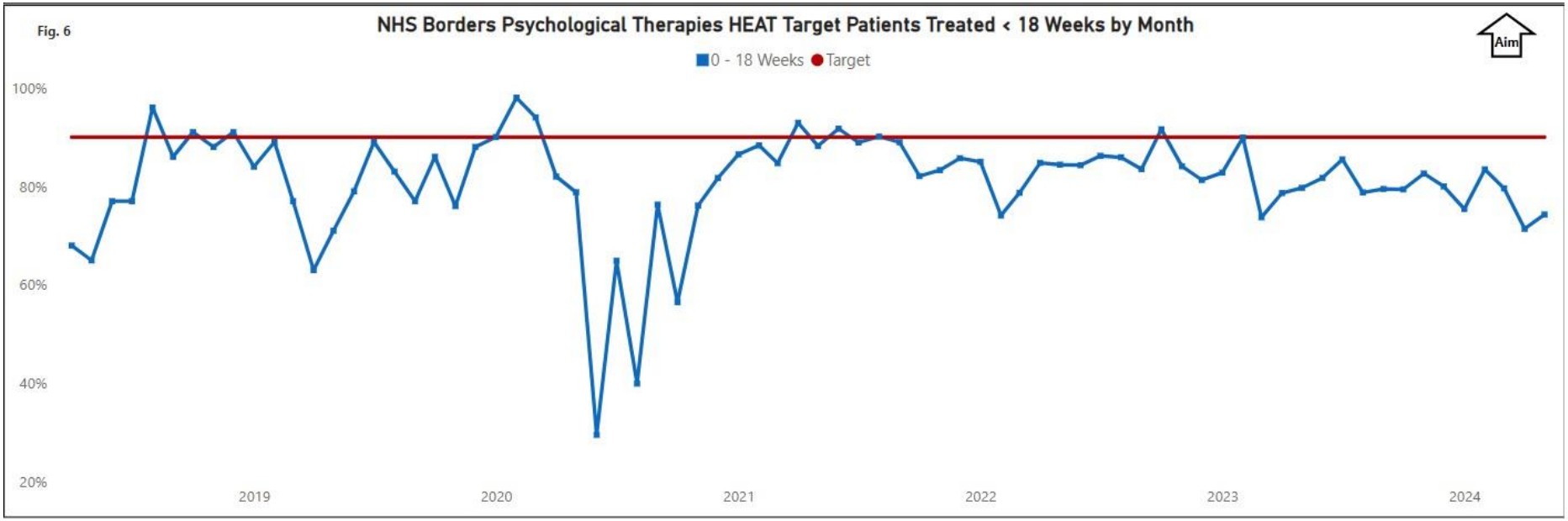
What is the data telling us?

During May 24, CAMHS continue to achieve the 90% HEAT Target of patients being seen within 18 weeks from referral to first appointment.

The table above is the current trajectory based on the current projected accepted referrals and number of treatments to be completed (12 New Patient Appointments per week 51 per month). Now that we are meeting the LDP (Heat target) the referrals and number of treatments are being weighted in favour of 90% Cat 1 and 10% Cat 2 due to the increase in ND Referrals. However, this will be reviewed monthly to maintain the Heat Target for Cat 2's.

Updated 12.07.24

Mental Health Waiting Times- Psychological Therapies



What is the data telling us?

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 has gone up from last month at 74.34% - last months was 71.43%. In May the service started treatment with 152 patients (126 in April 2024) of which 39 patients (36 in April) had waited longer than 18 weeks for a first treatment appointment (Figure 1).

Our LD and BAS psychology service is under great pressure with a known capacity gap. Older adult psychology is also under great pressure due to vacancies, this situation is likely to improve in the next few months as recruitment is under way. Adult mental health secondary care is under pressure due to unprecedented and sustained high referrals.

As at 31st May 2024 we have 536 people on our waiting list, a decrease of 13 from last month, 87.87% of whom have waited less than 18 weeks. We have 11 people waiting in the 35-52 week range which represent 2.1% of those waiting. We have no patients waiting over 52 weeks.

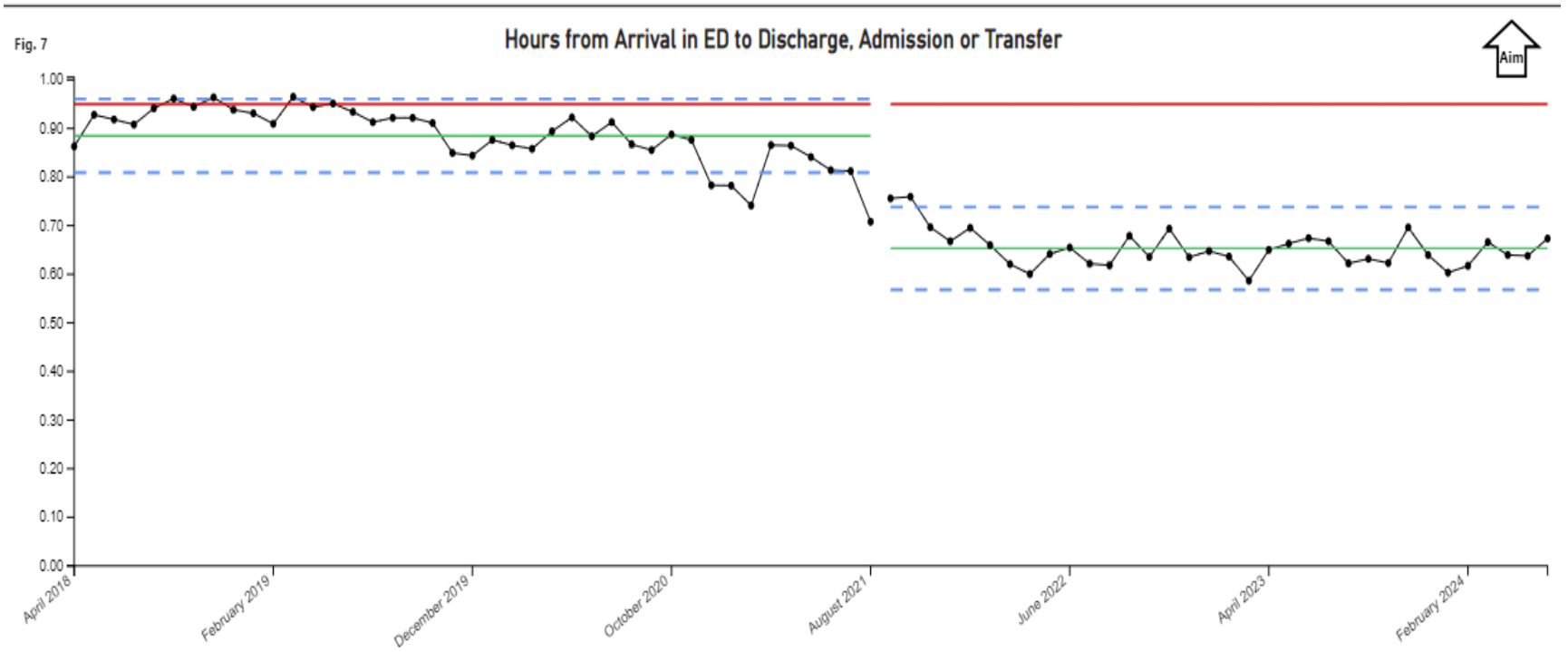
Waits over 18 weeks are mainly due to capacity issues and delays in secondary care psychology services, especially older adults, learning disability, substance misuse and adult mental health. For those areas which have had an increase in referrals, we are noticing a build-up of assessments, which will most likely impact on treatment waits.

Workforce

Our LD and BAS psychology services are under great pressure with known capacity gaps. Older adult psychology is also under great pressure due to vacancies, this situation is likely to improve in the next few months as recruitment is under way. Adult mental health secondary care is under pressure due to unprecedented and sustained high referrals.

Updated 19.07.24

Unscheduled Care Performance - 4 Hour Emergency Access Standard Performance



In June 2024 there were 2853 unplanned attendances to the Emergency Department (ED), with 932 breaches. Performance against the standard was 67.3% vs. 63.9% in May 2024 (an increase of 3.4%).

The BGH continued to face significant pressures throughout June associated with attendances, acuity, and flow with additional surge open for patients waiting longer than 4hrs for an inpatient bed.

The Emergency Department continued to see a high volume of waits over 4 hours in June 2024 but the volume of waits over 12 hours reduced. The delays were driven by wider system pressures, such as availability of beds and cubicles, time of day discharges and delayed discharges waiting on health or social care facilities, top 3 breach reasons outlined below:

1. Wait for a Medical Bed- 295 Patients- this is driven by wider pressures within the BGH (including discharging late into the day).

2. Wait for 1st ED Assessment- 116 Patients- this was impacted by the availability of physical space to assess patients and again is driven by wider pressures within the BGH

3. Wait for Treatment End- 77 Patients- patients who has a clinical reason for breaching the target for patients whose care cannot be delivered within the 4 hours EAS.

There were less days that saw 12-hour breaches in June compared to May 2024. During this month there were 7 instances when 12-hour breaches exceeded 10.

Updated 22.07.24

Delayed Discharge

Fig. 8

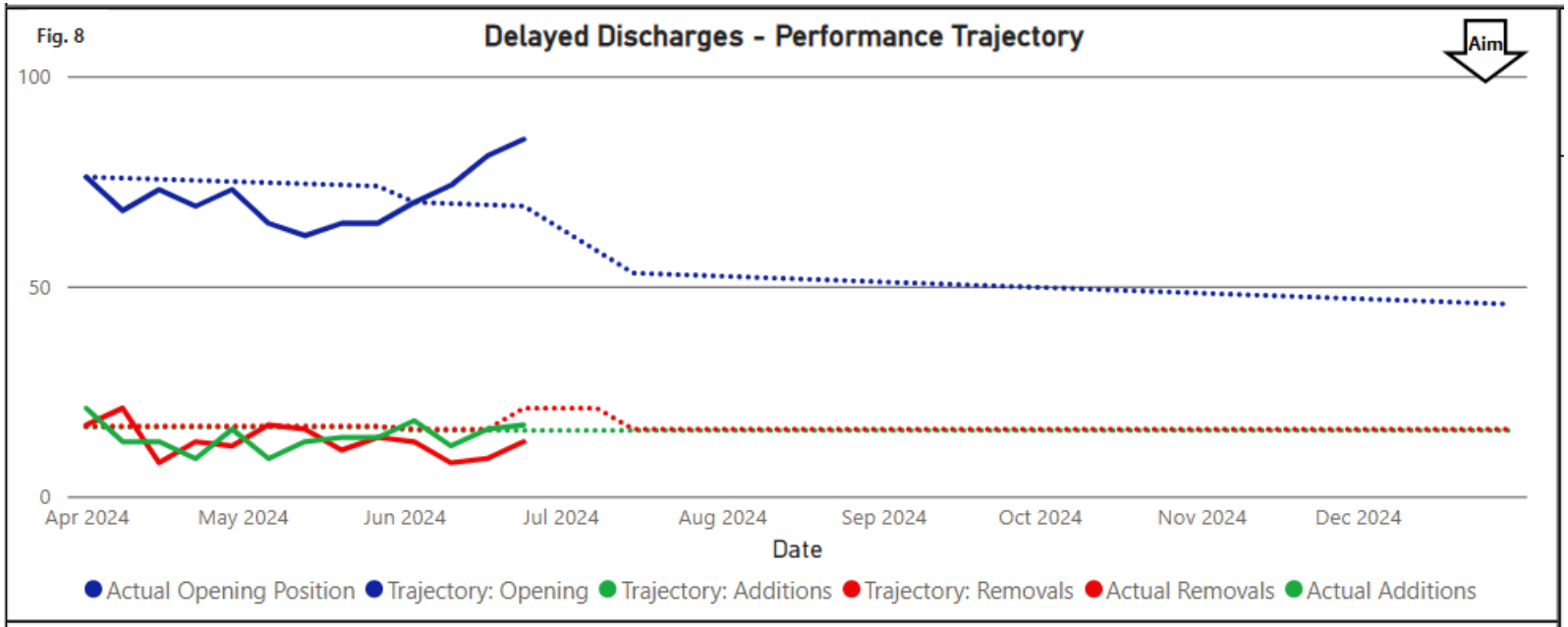
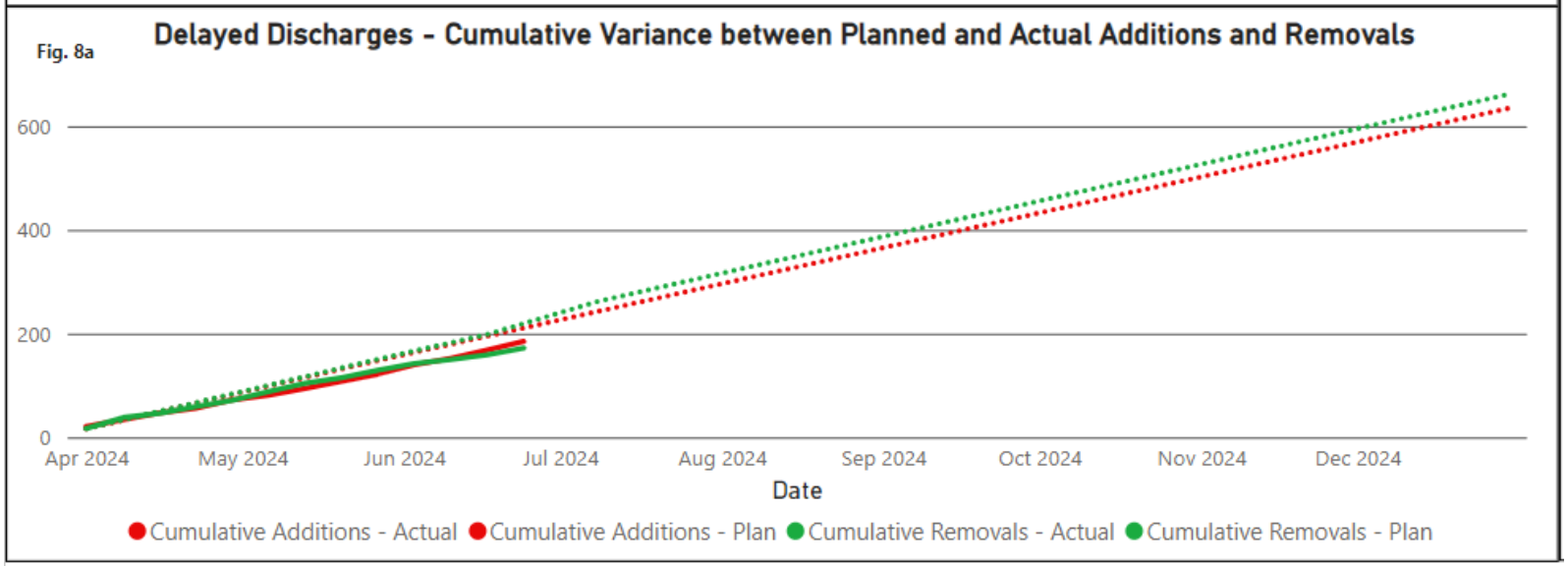


Fig. 8a



A new trajectory was agreed by the HSCP Joint Executive Team on 11 June 2024 based on the standard methodology of reviewing the previous 26 weeks of activity and any additional actions which gets delays to 46 by the end December. Since agreeing to this level, the Scottish Government have set out in a national Collaborative Assurance and Response Group on Delayed Discharges an expectation that the Scottish Borders returns to pre-pandemic levels of delays by 36 by the end of October.

Locally since 2019, we have seen an increase in demand for care from the hospital system by 33%. As noted in previous IJB meetings, work to increase social care capacity and redesign health and social care services has been essential in offsetting the increased demand, but has not sufficiently kept up with demand.

Calendar year	2019	2020	2021	2022	2023	2024 01/01-23/06
Weekly demand	12.05	10.88	11.84	12.73	14.21	16.04
Annual demand	626	566	616	662	739	834*
% growth from 2019	-	-10%	-2%	6%	18%	33%

*2024 total annual demand is an estimate based on weekly demand figures in the year to date

It is worth noting that:

- The current trajectory gets to 49 by end October (36 aim)
- The main challenge currently is that residential care demand outstrips supply.
- Further actions being considered locally:
    - Reducing social work assessment waits, pathfinder of discharge to assess, conversion of respite to enhanced residential care, development of integrated reablement service, further hospital system prioritisation
- The Chief Officer has escalated this position to the Collaborative Response and Assurance Group and has requested the following support:
    - Financial resourcing through revenue: To meet the increased demand associated to demographic growth, and to help us deliver the ambitions of returning to pre-pandemic levels of delayed discharge sustainably, we need to ensure that the additional capacity required is resourced
    - Workforce: Consideration of priority development of incentives in areas with lower workforce supply, such as rural areas. This could be on a pathfinder basis to address social care recruitment issues
    - Sharing of best practice in a collaborative way across Scotland
    - Financial resourcing for capital (medium term)

Updated 22.07.24

Appendix to Main Performance Scorecard – Performance Against Previous Agreed Standards

Key Metrics Report – AOP Performance

Current Performance Key

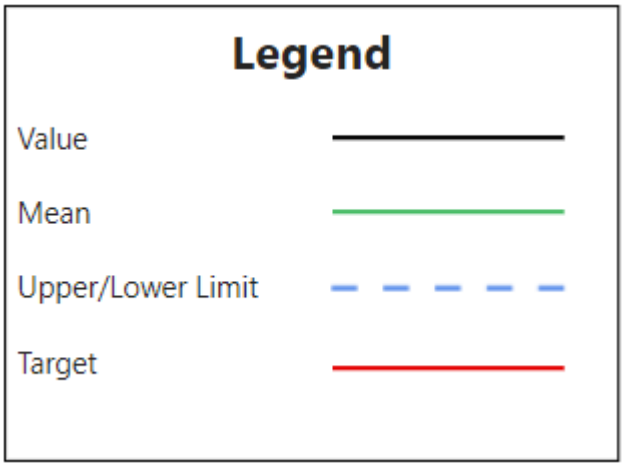
R	Under performing	Current performance is significantly outwith the trajectory/ standard set	Outwith the standard/ trajectory by 11% or greater
A	Slightly Below Trajectory/ Standard	Current performance is moderately outwith the trajectory/standard set	Outwith the standard/ trajectory by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory/standard set	Overachieves, meets or exceeds the standard/trajectory, or rounds up to standard/trajectory

Symbols

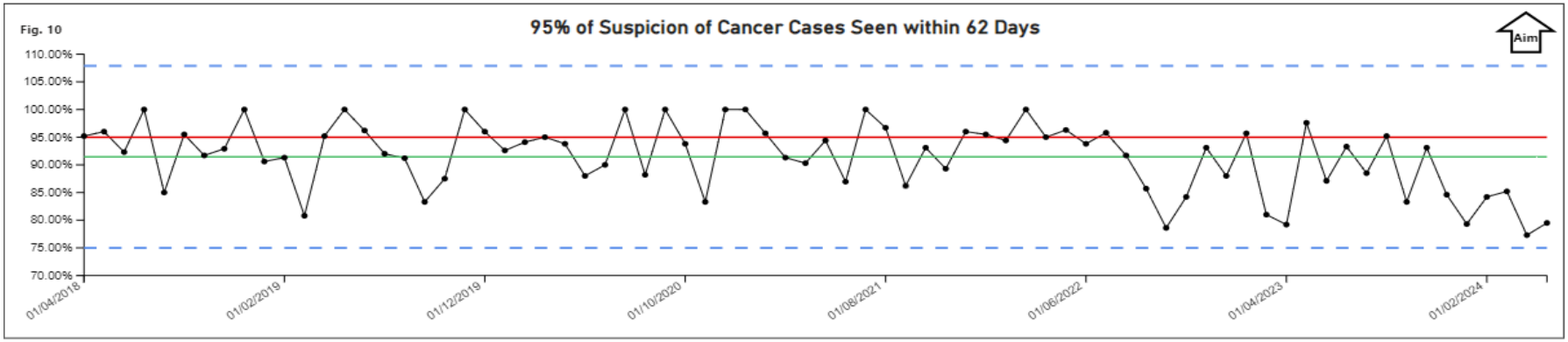
Better performance than previous month	↑
No change in performance from previous month	↔
Worse performance than previous month	↓
Data not available or no comparable data	-

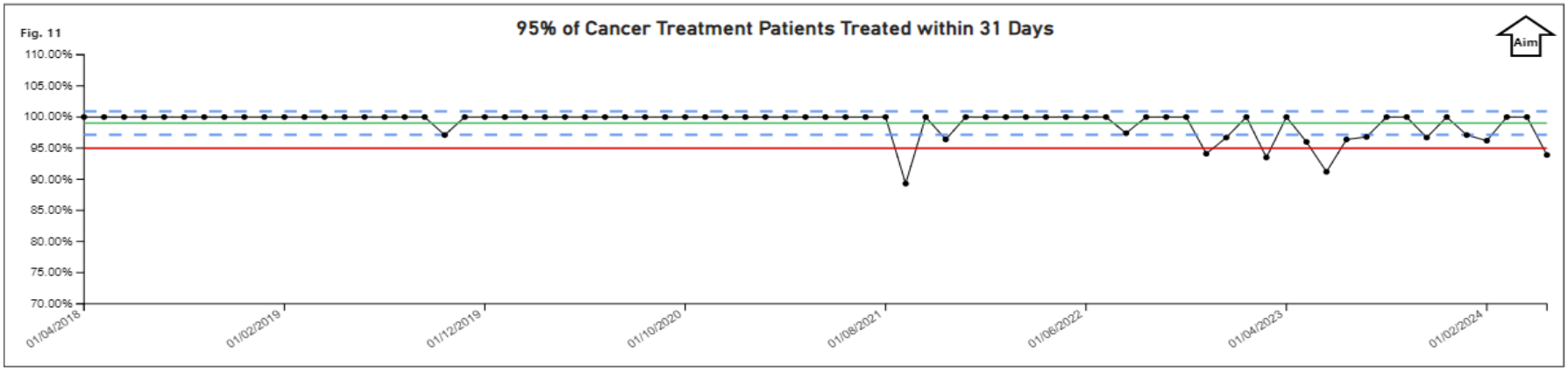
Key Metrics Report Annual Operational Standards

Index	Measure	Target/Standard	Last Period	Last Position	Current Period	Current Position	Comparison
6	Referral to Treatment (RTT) - % treated within 18 weeks of referral	90% patient to be seen and treated within 18 weeks of referral.	01 May 2024	0.67	01 June 2024	0.66	↓
11	Psychological Therapies - % treated within 18 weeks of referral	90% patient treated within 18 weeks of referral	01 March 2024	0.80	01 May 2024	0.74	↓
12	Drug & Alcohol - Treated within 3 weeks of referral	90% patient treated within 3 weeks of referral	01 December 2023	1.00	01 March 2024	0.99	↓
8	CAMHS - % treated within 18 weeks of referral	90% patients seen and treated within 18 weeks of referral	01 March 2024	0.42	01 May 2024	0.89	↑
9	A&E 4 Hour Standard - Patients discharged or transferred within 4 hours	95% of patients seen, discharged or transferred within 4 hours	01 May 2024	0.64	01 June 2024	0.67	↑
2	Cancer waiting Times - 31 Day target	95% of patients treated within 31 days of diagnosis	01 April 2024	1.00	01 May 2024	0.94	↓
1	Cancer Waiting Times - 62 Day Target	95% patients treated following urget referral with suspicion of cancer within 62 days	01 April 2024	0.77	01 May 2024	0.80	↑
13	Sickness Absence Rates	Maintain overall sickness absence rates below 4%	01 May 2024	0.06	01 June 2024	0.06	↓
10	Delayed Discharges - Patients delayed over 72 hours	Zero patients delayed in hospital for more than 72 hours	31 May 2024	60.00	30 June 2024	61.00	↑
5	Treatment Time Guarantee - Number not treated within 84 days from decision to treat	Zero patients having waiting longer than 84 days.	31 May 2024	133.00	30 June 2024	160.00	↑
4	New Inpatients - Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	31 May 2024	2,222.00	30 June 2024	2,156.00	↓
3	New Outpatients - Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	31 May 2024	7,669.00	30 June 2024	7,724.00	↑
7	Diagnostics (8 key tests) - Number waiting >6 weeks	Zero patients waiting longer than 6 weeks for 8 key diagnostic tests	01 May 2024	309.00	01 June 2024	240.00	↓


Legend
Value
Mean
Upper/Lower Limit
Target

Cancer Waiting Times





Stage of Treatment - Outpatients/Inpatients waiting over 12 weeks

Fig. 12 Stage of Treatment Target – Outpatients Waiting Over 12 Weeks

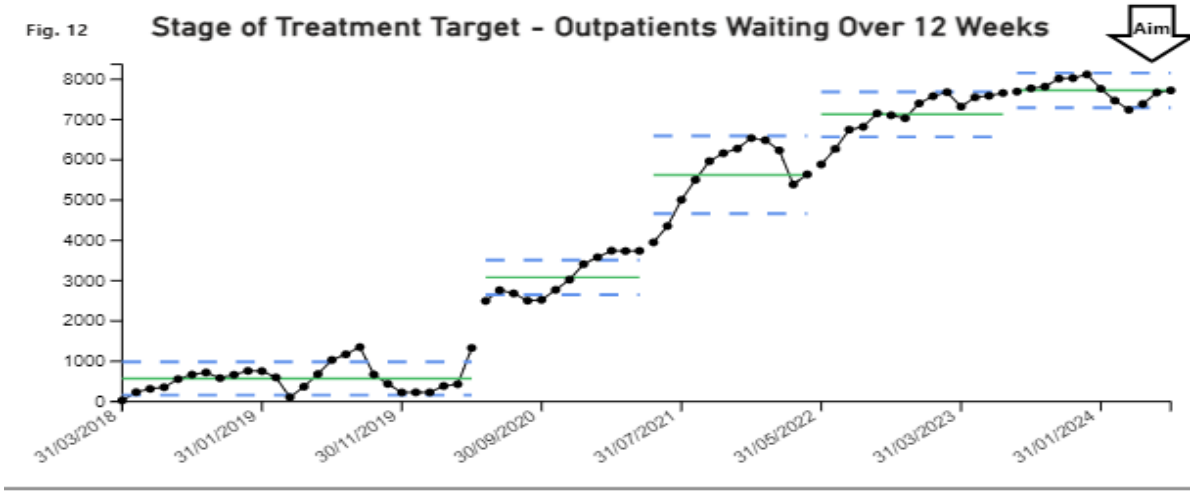
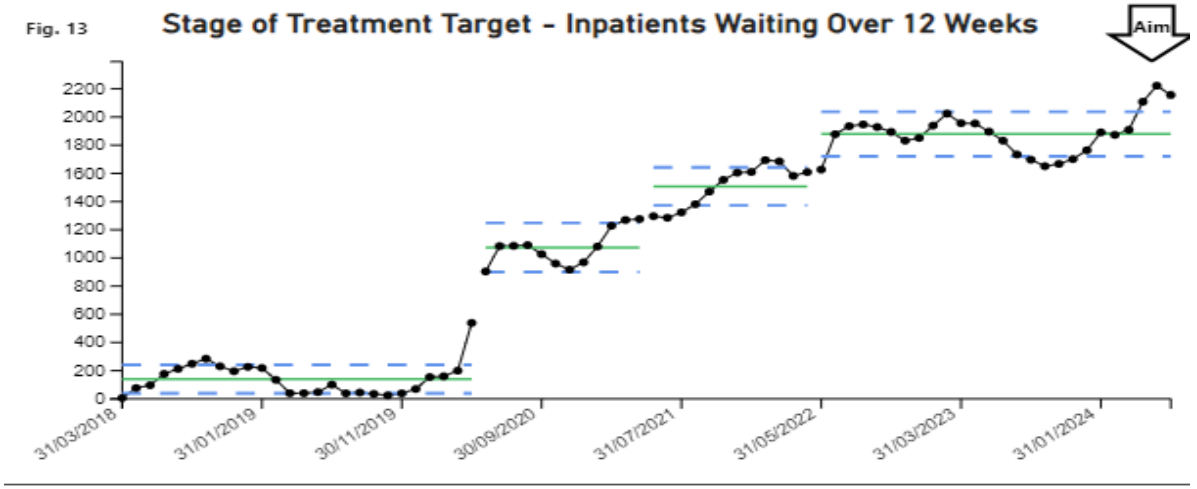
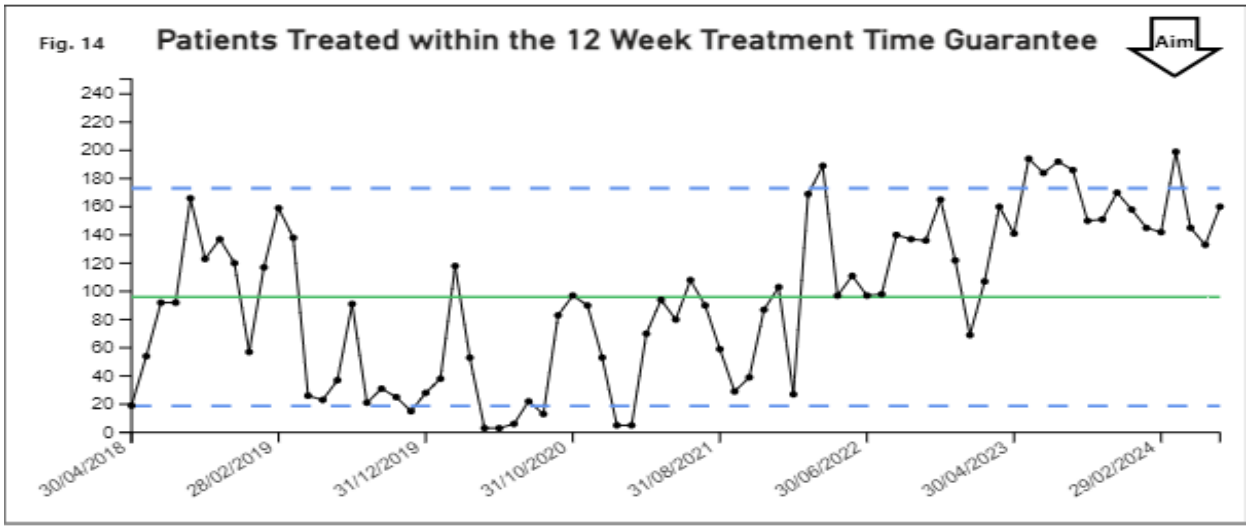
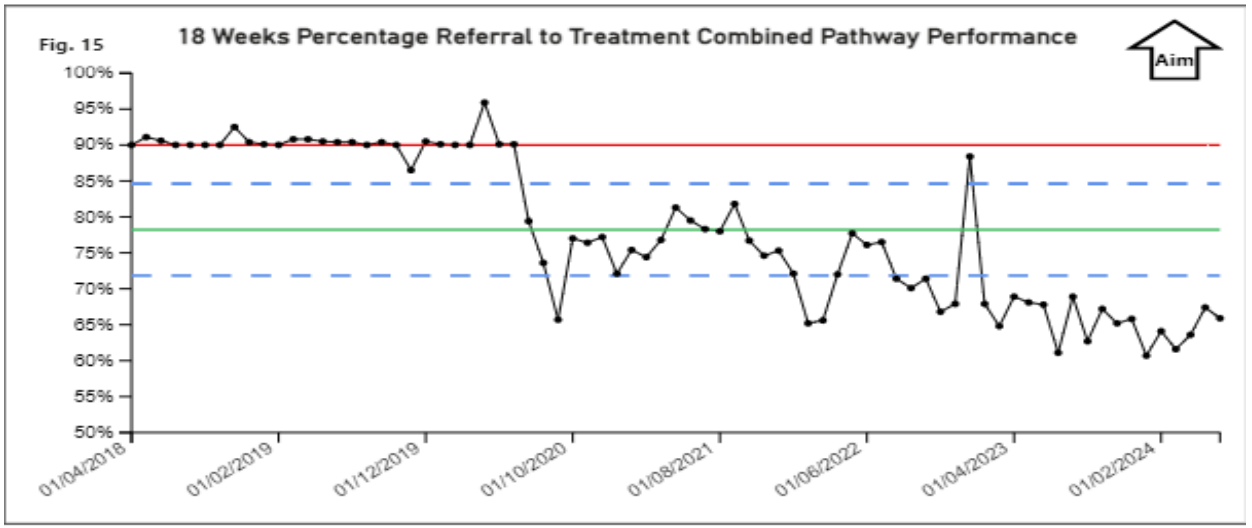


Fig. 13 Stage of Treatment Target – Inpatients Waiting Over 12 Weeks

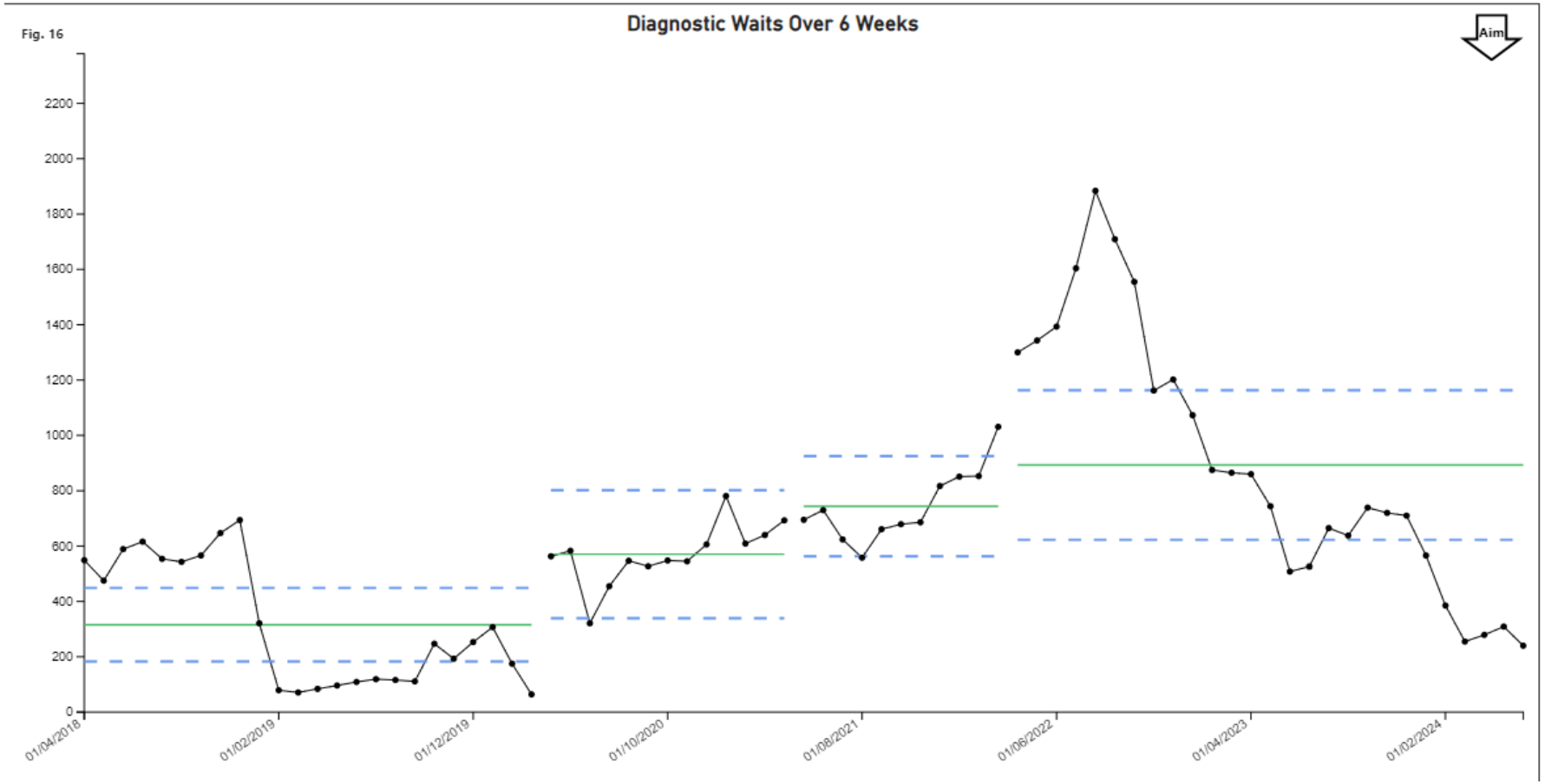


Treatment times

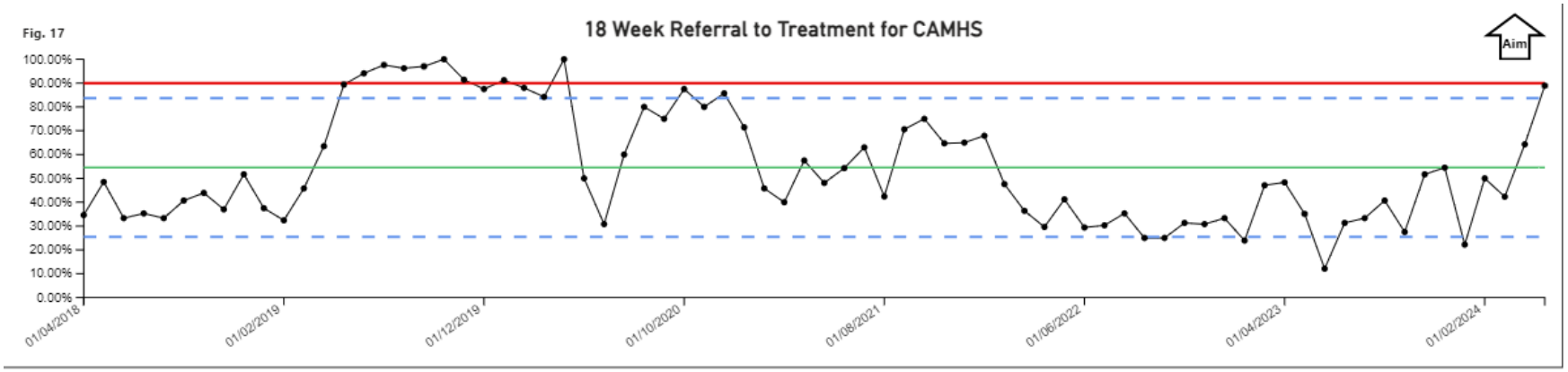


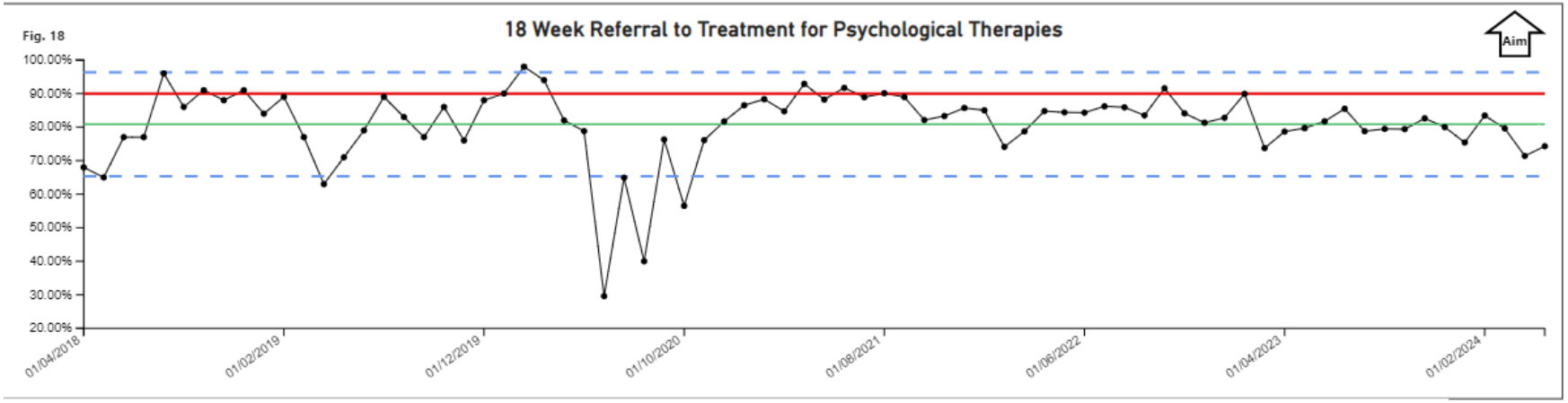


Diagnostic Waits

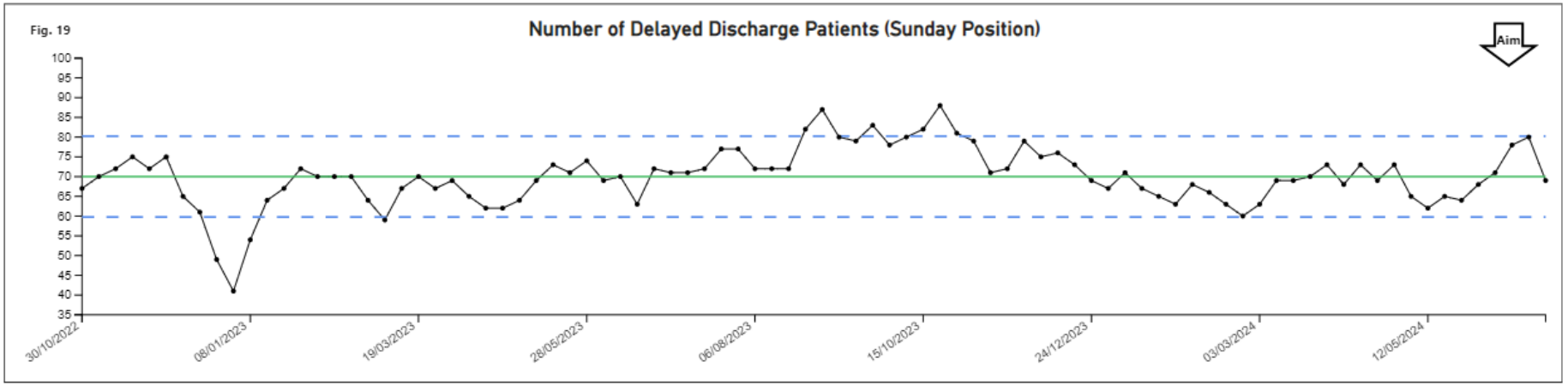


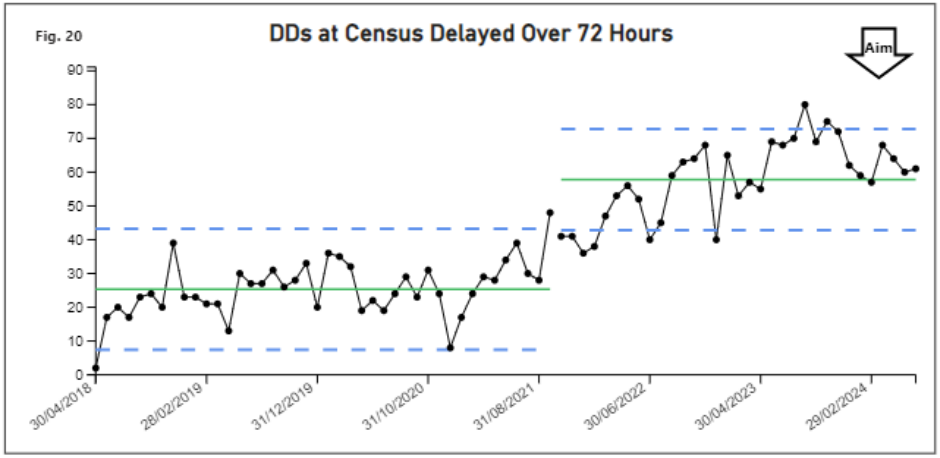
Mental Health

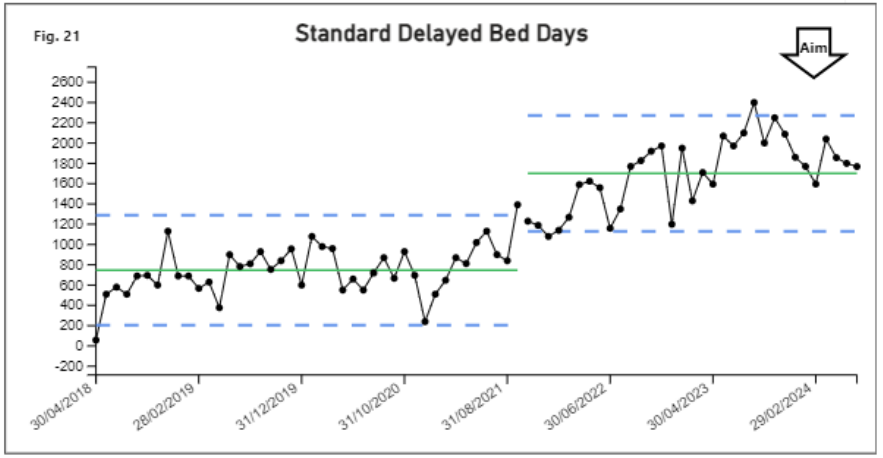




Delayed Discharges

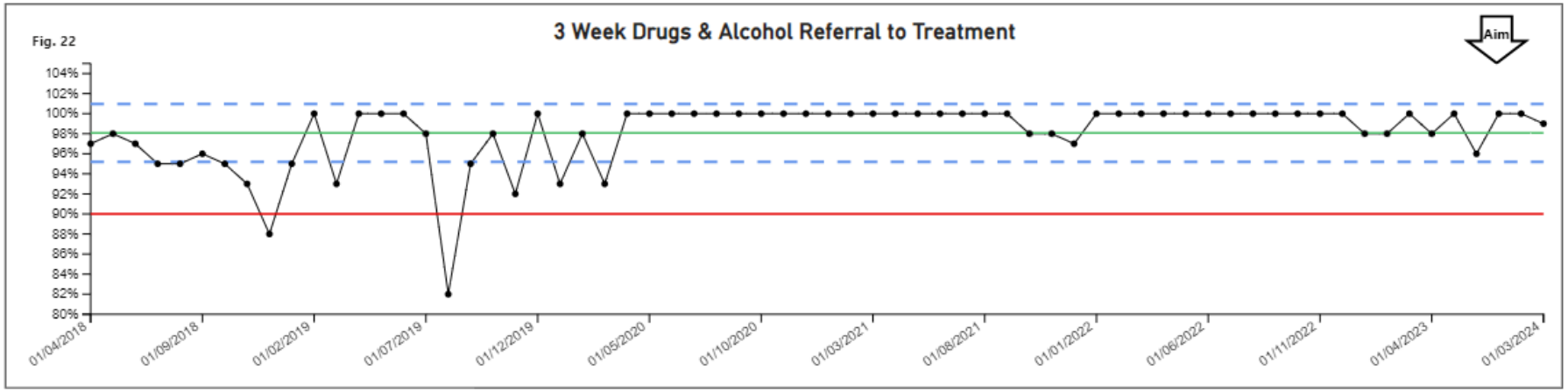






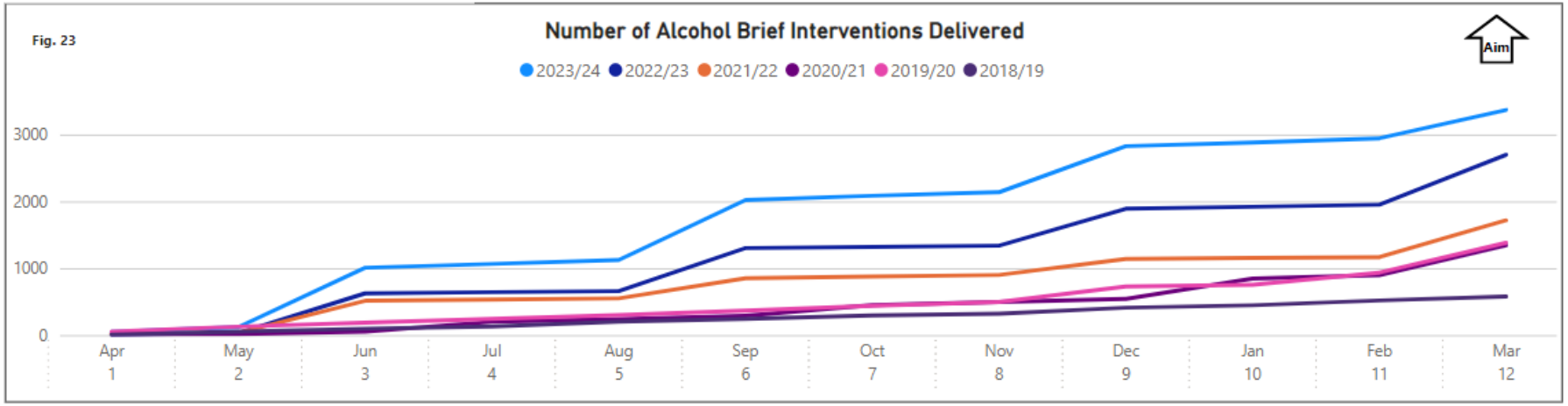
Drugs & Alcohol

Fig. 22



Note: Updates provided Quarterly

Fig. 23

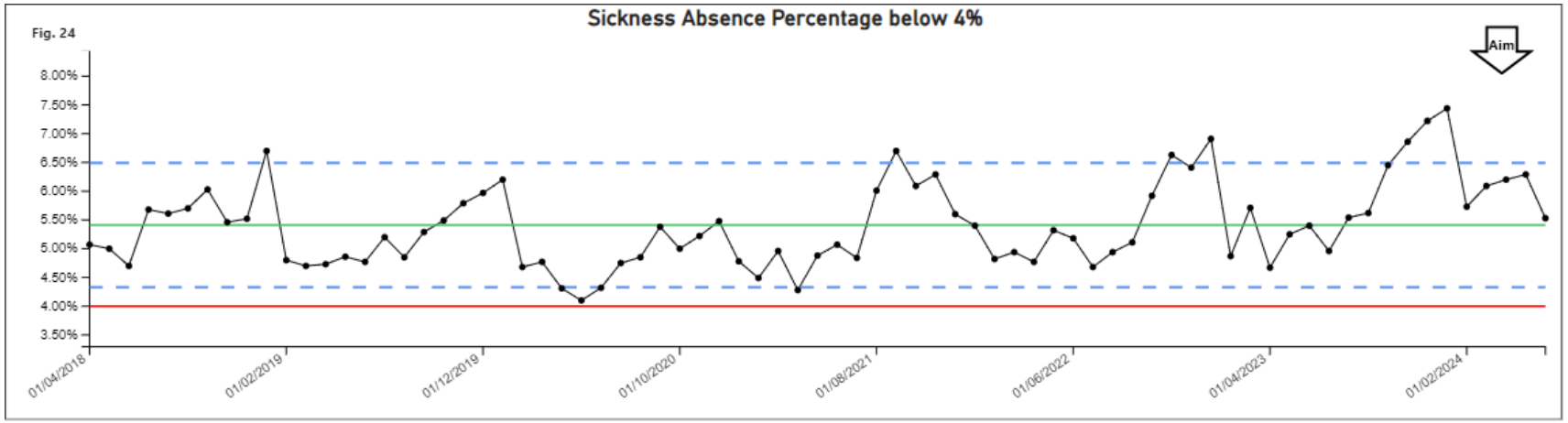


Please Note: Standard is 1312 by end of March every year, it then resets back to 0 every April and cumulative reporting starts again.

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

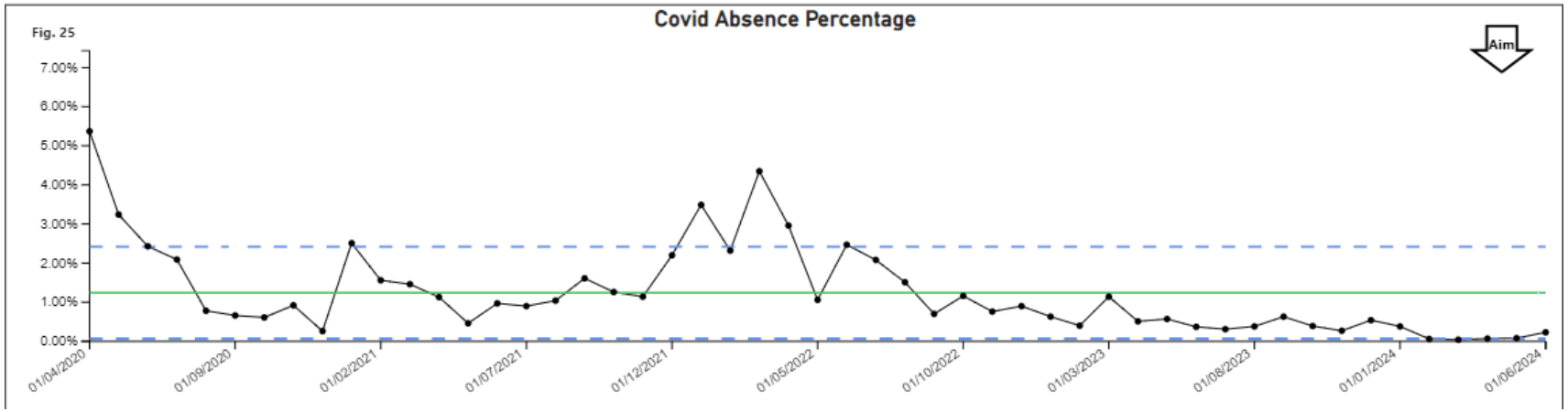
Sickness Absence

Fig. 24



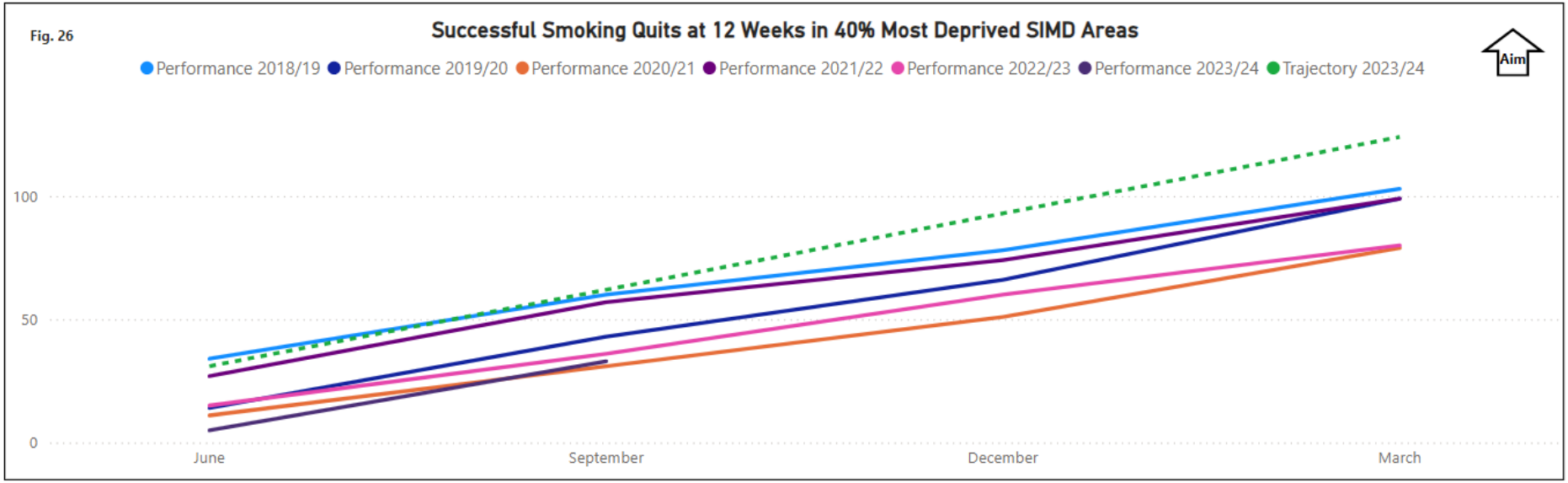
Note: Sickness absence data does not includes any COVID-19 related absences.

Fig. 25



Smoking Quits

Latest NHS Scotland Performance (2019/20)	NHS Borders Performance (2019/20)
97.20	77.40



(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)