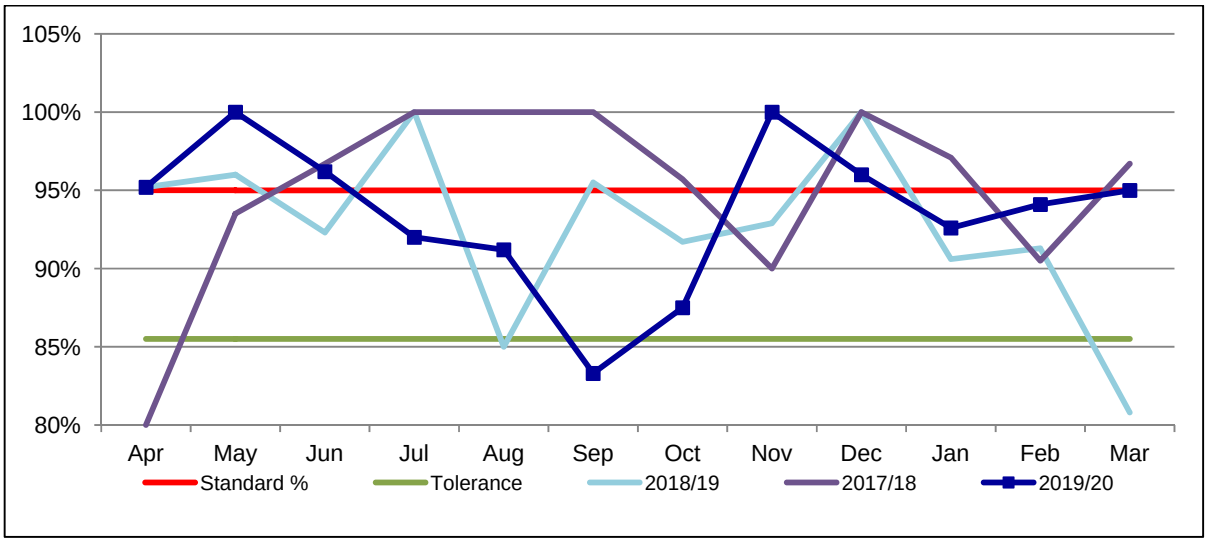
2020 Annual Review

CONTENTS

SECTION 1: PRE-COVID PERFORMANCE: 2019/20

Performance Measure:
95% of all cases with a Suspicion of Cancer to be seen within 62 days

2019/20 Standard	Current Standard	March 2020 Position	March 2020 Status
95%	95%	95%	G



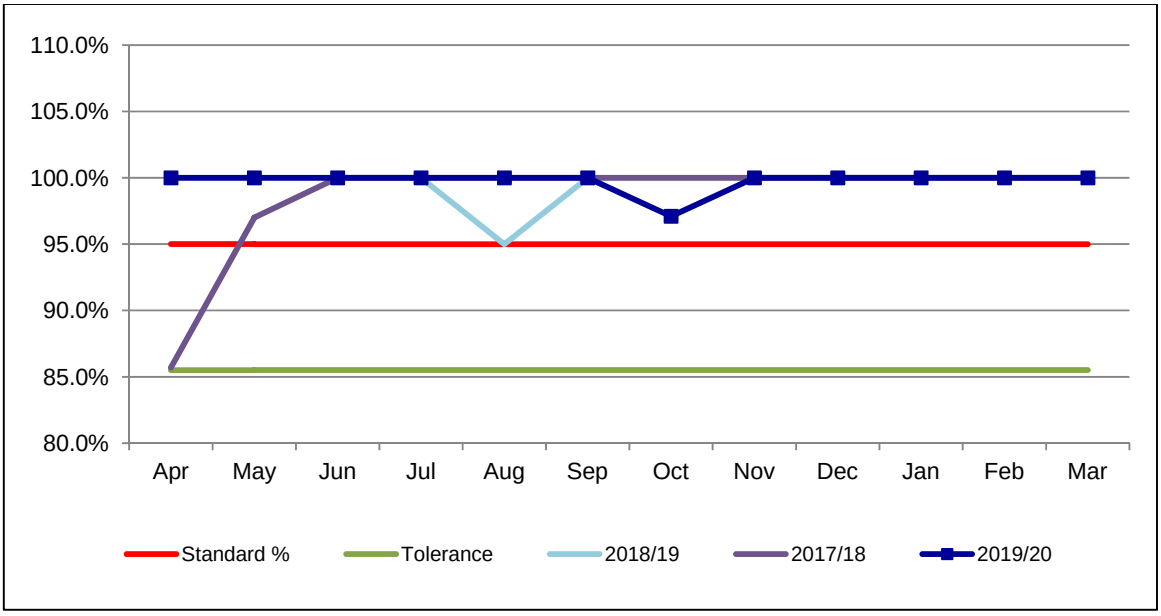
Performance during the first two quarters of 2019/20 fell due to capacity issues within Colonoscopy and pathway delays within Urology (Prostate). This improved following confirmation of the Cancer Waiting Times funding provided by Scottish Government at the end of July 2019.Introduction of a Cancer Service Management Lead and a programme of improvement work that reviewed pathways, strengthened tracking and active management of pathways, all supported improved performance.

Urology – Historically there have been a number of delays in patient pathways mainly from the time to refer, to diagnostic tests for prostate patients within NHS Borders and waits for surgical assessments and treatment in NHS Lothian. Prior to COVID-19, work was underway to improve this process which made significant headway by removing an initial assessment and referring patients straight to MRI from referral for the Borders General Hospital (BGH) pathway, however issues are still prevalent for patients referred for treatment in NHS Lothian.

Colonoscopy – Capacity issues within the service were rectified in February 2020 with the recruitment of a new Gastroenterology consultant and relocation of the Cystoscopy service to the Day Procedure Unit to provide additional Colonoscopy sessions within the Endoscopy suit. This capacity increase should ensure that we can manage demand without relying on the independent sector.

Performance Measure:
95% of all patients requiring Treatment for Cancer to be seen within 31 days

2019/20 Standard	Current Standard	March 2020 Position	March 2020 Status
95%	95%	100%	G



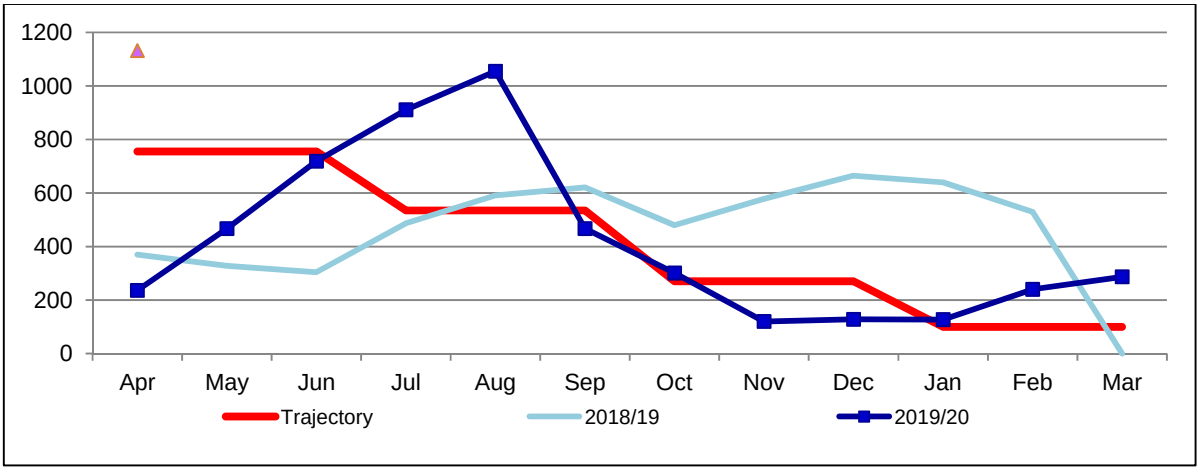
NHS Borders has achieved 100% performance for the **31 day standard** 11 months out of 12 in 2019/20.

Drops in performance can be quite significant as the number of patients we treat is relatively small and one breach can reduce our performance by around 5%. This is due to the small number of patients treated on 31 day pathways within the board. In some months, one patient can equate to more than 5% meaning we miss our trajectory.

Introduction of a Cancer Service Management Lead and a programme of improvement work that reviewed pathways, strengthened tracking and active management of pathways, all supported improved performance

Performance Measure:
12 weeks for Outpatients

2019/20 Standard	Current Standard *	March 2020 Position	March 2020 Status
0	100	287	R



*Performance in 2019/20 is being measured against an agreed trajectory rather than the standard of 0 patient waits.

We were on target to hit the target of 100 patients over 12 weeks at the end of March with capacity provided by an independent sector organisation but due to COVID-19 this did not happen and resulted in us missing trajectory.

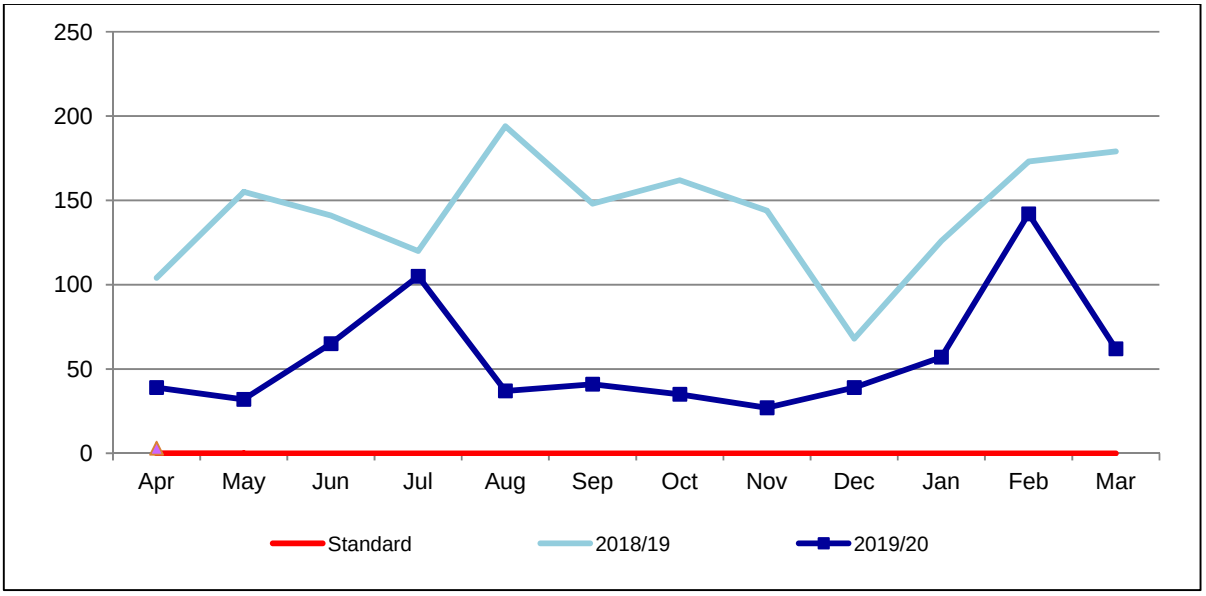
Overall performance has improved in 2019/20 when compared to 2018/19, with the trajectory being met 6 months out of 12, although there was a decline in January, February and March 2020.

Following a delay in funding confirmation from the Scottish Government, we were unable to commence any waiting list initiative work until this was confirmed in late July 2019. This resulted in increasing breaches until August 2019 at which point additional lists were undertaken to reduce the backlog of breaching patients across all elective specialties to achieve the Q2 performance target for 2019/20.

A new performance management system that included better use of performance trajectories and data modeling helped ensure strong performance following implementation from summer 2019.

Performance Measure:
12 Weeks Treatment Time Guarantee

2019/20 Standard	Current Standard	March 2020 Position	March 2020 Status
0	0	62	R



Pre-COVID, NHS Borders was on target to achieve 190 patients over 12 weeks as at 31st March 2020 however due to the cessation of operating in response to the pandemic, the Board missed this trajectory.

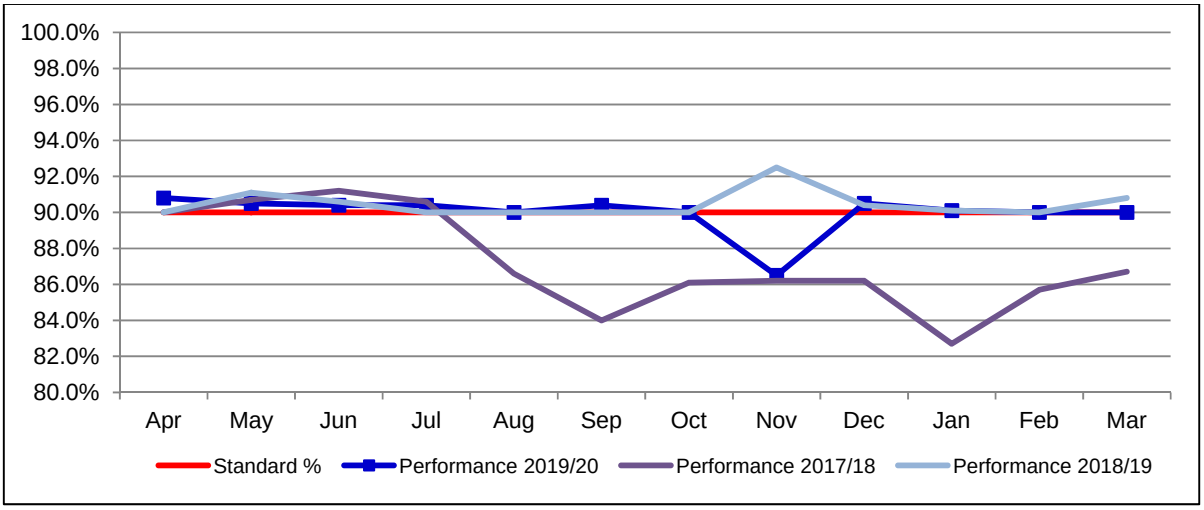
The number of patients breaching their **Treatment Time Guarantee** (TTG) decreased over 2019/20 compared to 2018/19. In March 2020, 62 patients who previously breached their TTG date were treated compared to 179 in March 2019. This was due to a reduction in theatre capacity due to COVID-19.

In February, there was a spike in treated TTG breaches and this was due to patient sendaways to Washington Spire following additional Government funding.

A new performance management system that included better use of performance trajectories and data modeling helped ensure strong performance following implementation from summer 2019.

Performance Measure:
18 Weeks Referral to Treatment Combined Performance

2019/20 Standard	Current Standard	March 2020 Position	March 2020 Status
90%	90%	90%	G

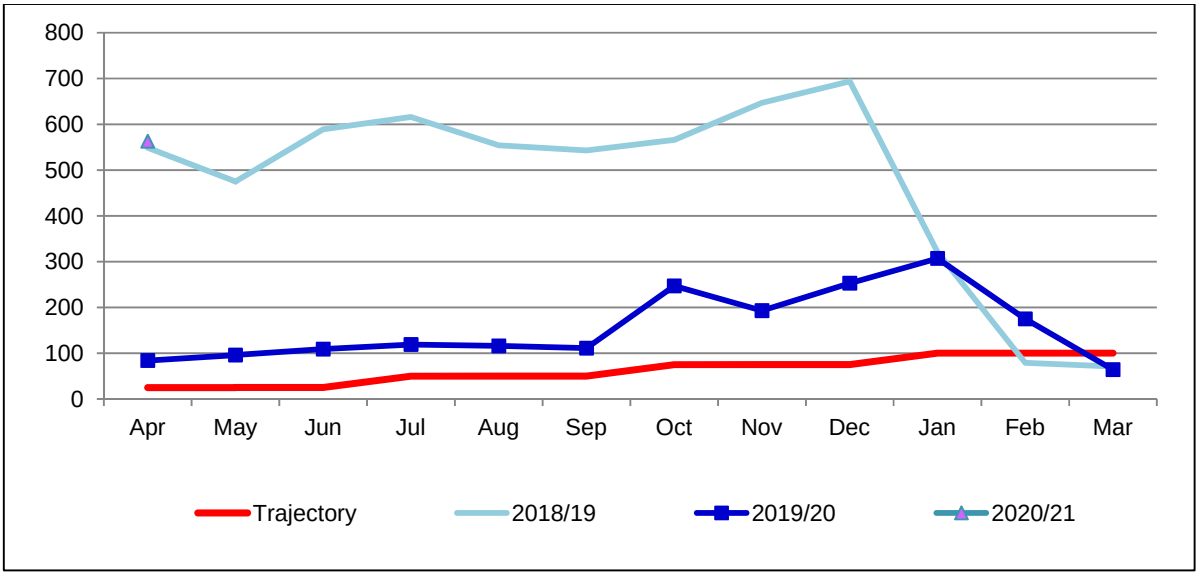


*Performance in 2019/20 is being measured against an agreed trajectory rather than the standard of 0 patient waits

NHS Borders has consistently achieved the 90% **18 weeks combined performance** standard in 2019/20 with the exception of November when it was below standard but within tolerance (86.5%). This was due to additional Waiting List Initiative clinics run during July and September 2019 for Outpatients that were then subsequently treated in November along with clinics run in November before the Christmas period begun.

Performance Measure:
6 Week Waiting Target for Diagnostics

2019/20 Standard	Current Standard	March 2020 Position	March 2020 Status
0	100	64	G



Performance against the **6 week diagnostic waiting time** standard has improved and the end March 2020 trajectory was achieved despite the impact of COVID-19.

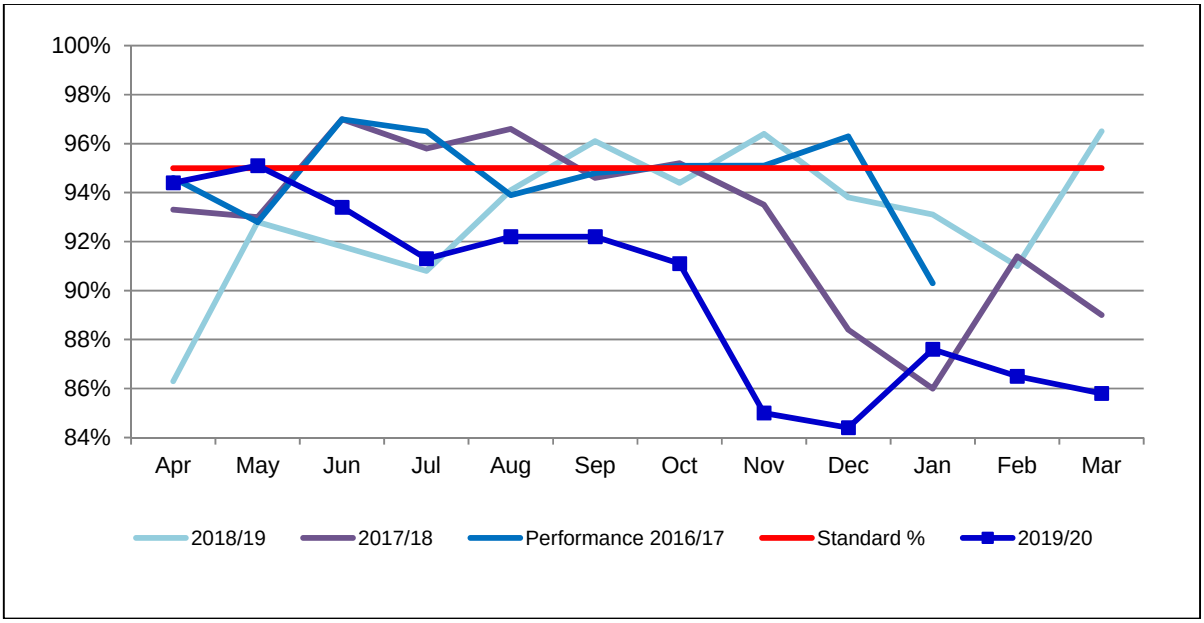
Colonoscopy & Endoscopy – Capacity has been increased through the recruitment of additional Consultant sessions to provide three additional Colonoscopy lists per week from January 2020. As a result of this, the agreed Waiting Times trajectory was met at the end March. There will however be challenges in future as a result of COVID-19 pandemic.

Magnetic Resonance Imaging (MRI) &Computerised Tomography (CT) – A significant volume of additional activity took place during 2019/20, and again the agreed trajectory was achieved at March 2020. Following the impact of COVID-19, work is ongoing to develop a plan to maintain this position going forwards, including development of a proposal to install the newly purchased MRI scanner as a second device.

Ultrasound – There are ongoing staffing issues around Ultrasound, but once again agreed trajectories were achieved at end March. An additional machine is likely to be required to maintain this position in light of COVID-19, and discussions are ongoing as to how to resource this.

Performance Measure:
Accident & Emergency 4 Hour Standard

2019/20 Standard	Current Standard	March 2020 Position	March 2020 Status
95%	95%	85.8%	A



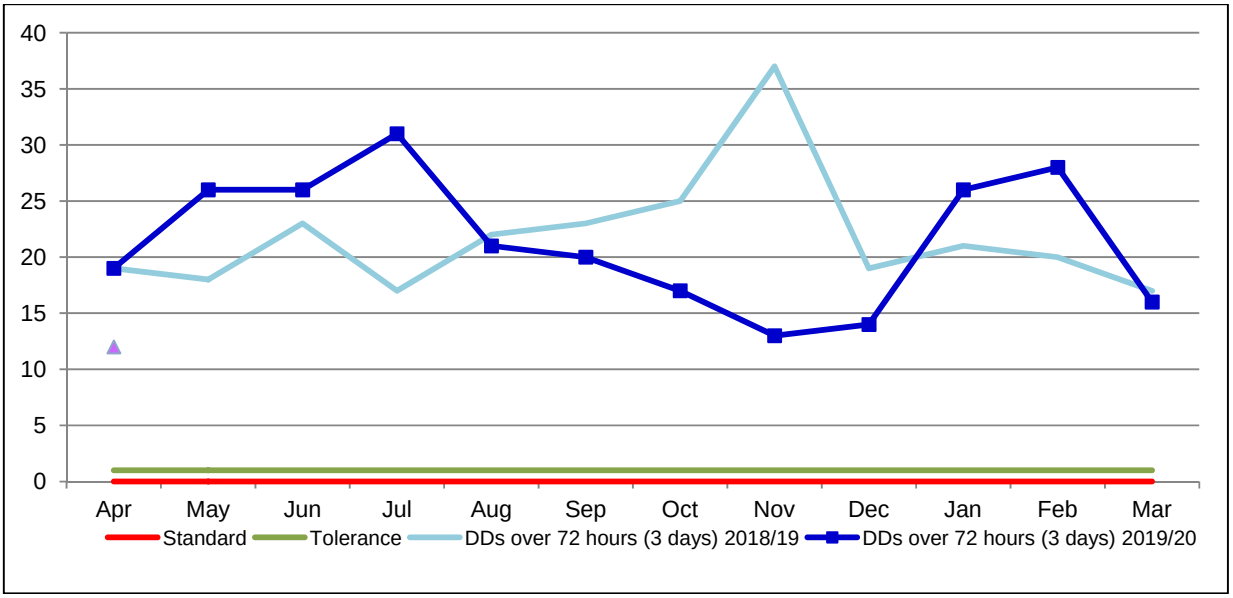
NHS Borders has only been able to achieve the **Accident & Emergency 4 Hour standard** one month in 2019/20.

The following key developments and activities remained ongoing until the point of initiation our COVID-19 mobilisation plan were:

- Daily Dynamic Discharge programme at BGH
- 7-day Site and Capacity Team
- Discharge Lounge utilisation project
- Continuation of Hospital to Home service for central Borders
- Process improvement work at BGH
- Seven day AHP Rapid Assessment and Discharge Service (RAD)

Performance Measure:
Delayed Discharges

	2019/20 Standard	Current Standard	Mar 2020 Position	Mar 2020 Status
Performance Measure: Delays over 2 weeks	0	0	13	R
Performance Measure: Delays over 72 hours (3 days)	0	0	16	R



A recent Health & Social Care Scotland report concluded that historical problems with delayed discharges are:

1. Been compounded by deep rooted behavioral issues, different organisational and professional cultures leading to a lack of trust in which the default position has become staying in hospital.
2. With hospitals being increasingly busy, staff tended, by necessity, to move on to the next crisis and the delayed patient could be forgotten, with all the known harmful consequences of deterioration and deconditioning.
3. Leading to a blame culture where people don't trust each other there is a tendency to blame each other when things go wrong.
4. As the delayed discharge numbers kept getting higher and higher, there was an acceptance of failure, fed by a perception of futility. Bad became the norm and nothing changed because everyone reverted to how things had always been done.

Until the COVID-19 pandemic, when everything changed. With the onset of the COVID-19 outbreak it was clear that delayed discharges needed to reduce, both in order to free up hospital capacity and to create a better outcome for individuals at risk of acquiring infection in hospital.

In the Borders we reduced delayed discharges massively. On the 28th March 2020 we had a total of 42 delays in the system (standard and complex) and by the 8th April this had reduced to 13.

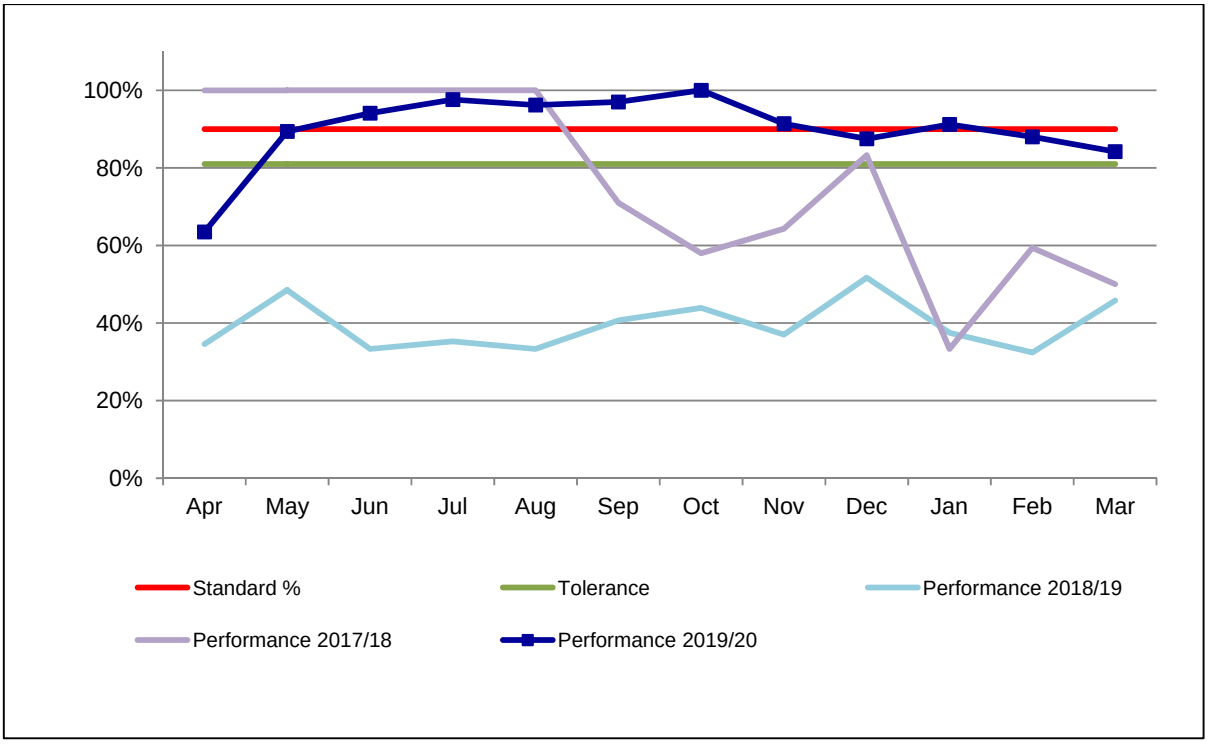
Demonstrating that delays can be tackled using a whole-system approach and that the historical cycle highlighted in points 1-4 above can be broken.

Since the COVID-19 peak, delayed discharge in the Borders are increasing. At the end of August 2020 cases had increased back to 32 (29 standard and 3 complex).This cannot be allowed to happen and as such an audit of delayed discharges commenced September 2020. This audit will review and assess the effectiveness of the processes and controls in place to manage and reduce delayed hospital discharges and cover:

- Delayed discharge volumes before, during, and in the recovery stages of the pandemic and how trends and issues are identified and reported.
- The arrangements in place for discharging patients in Borders General Hospital as well as community hospitals
- Evaluation of the controls over the decision-making processes with consideration given to compliance policies and procedures, and staff's understanding of care facilities available within the community.

Performance Measure:
No CAMHS waits over 18 weeks

2019/20 Standard	Current Standard	March 2020 Position	March 2020 Status
90%	90%	84.2%	A



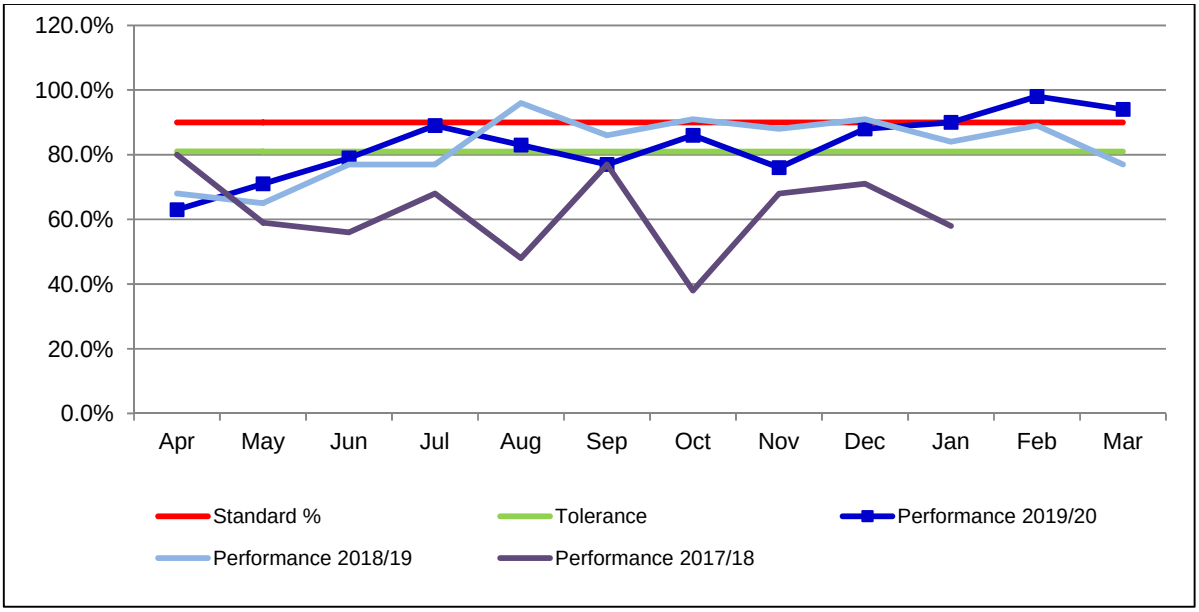
There has been a significant improvement in performance in 2019/20 from 2018/19 with the standard only being outside of tolerance for 1 month of the reported 11 and above standard for 7 months. The February 2020 reported position was 88.0% compared to 32.4% in February 2019.

Work continues within the service to ensure that the achievement is sustainable however COVID-19 and staff sickness has had a significant impact on the CAMHS service in 2020. This has had a detrimental effect on our ability to meet our performance standard and as a result we have significant waiting lists.

We are currently working with the Scottish Government to implement strategies to remedy this situation.

Performance Measure:
No Psychological Therapy waits over 18 weeks

2019/20 Standard	Current Standard	March 2020 Position	March 2020 Status
90%	90%	94.0%	G



Please Note: Psychological Therapy data for September 2017 to July 2018 is provisional, it does not include all activity due to transition to EMISreporting

Performance had been outwith of standard throughout the first nine months of 2019/20; however performance improved steadily which saw the performance standard consistently achieved from January 200 to March 2020 where performance was 94.0% as opposed to 77.0% in March 2019. This was in part due to extra staff recruited who started in October 2019, including fixed term staff.

However, the impact of COVID-19 has negatively impacted on our ability to meet the target for the remainder of 2020. We switched as many appointments as possible to Attend Anywhere, some services did not suit this approach and we were unable to roll out group programs as planned. Waiting Times have increased as a result. Ensuring the service has the correct resource going forward is going to be critical in ensuring our ability to meet the standard.

SECTION 2: COVID-19: INITIAL RESPONSE

As we move out of respond phase to COVID-19 and start to plan for the remobilisation of our services, NHS Borders is continually reviewing what went well during the response phase and what lessons can be learnt. Feedback has been sought from key stakeholders across the organisation over a series of discussions. This resulted in a number of key themes being identified around positive changes that have been introduced as a result of the pandemic which staff want to retain. These are summarised below:

Positive' changes / behaviours to retain

- Rapid deployment of digital tools and alternative contacts for activities like one-to-one patient consultations, inpatient family contact and internal staff meetings such as Near Me / Telephone etc…
- Central COVID-19 Hub and assessment area to provide streamlined care
- Integrated working / increased social care capacity – reduced delayed discharges
- Clear intermediate care pathway utilising AHP's, hospital to home service "Home First" & bed based intermediate care in 24 hour care settings
- Primary Care enhanced access to diagnostic interventions – supporting urgent cancer referral decisions
- Creation of multi-disciplinary, multi-agency locality hubs involving health, social care and third sector
- Greater use of physiotherapists in delivering respiratory care
- A smaller inpatient footprint for paediatrics and re-imagined ways of managing day cases
- A new admission process for MH inpatient admissions (including out of hours) to reduce risk of infection
- MH Crisis Service – introduced service changes which enabled reduced presentations to ED
- Centralised functions mobilised to support response e.g. staff accommodation, absence line, transport hub, redeployment & staff hub
- Implementation of Staff Wellbeing Plan / Psychological Hub 'Here 4 u'

These ideas are being considered as part of individual services remobilisation plans and will be considered within our local prioritisation process.

In addition to the above we have undertaken conversations with the leadership team across NHS Borders to identify some key points that we would want to learn from moving forward. These include the following:

- Clinical / Staff empowerment
- Clinical leadership / ownership / engagement
- Patient led & clinician driven treatment – Realistic Medicine principles
- "improved" & streamlined decision making
- Greater collaboration between NHS services and partner services
- Stronger links between health & social care
- Increased use 'self management techniques'

- Streamlined, simple, rapid processes (without losing outcomes)
- Improved communication with care home managers

As part of our engagement programme around remobilising our services we continue to share these points and will add to them as required. We have shared these initial thoughts with colleagues in social care and the IJB, who have confirmed similar findings through their reflections on responding to COVID-19.

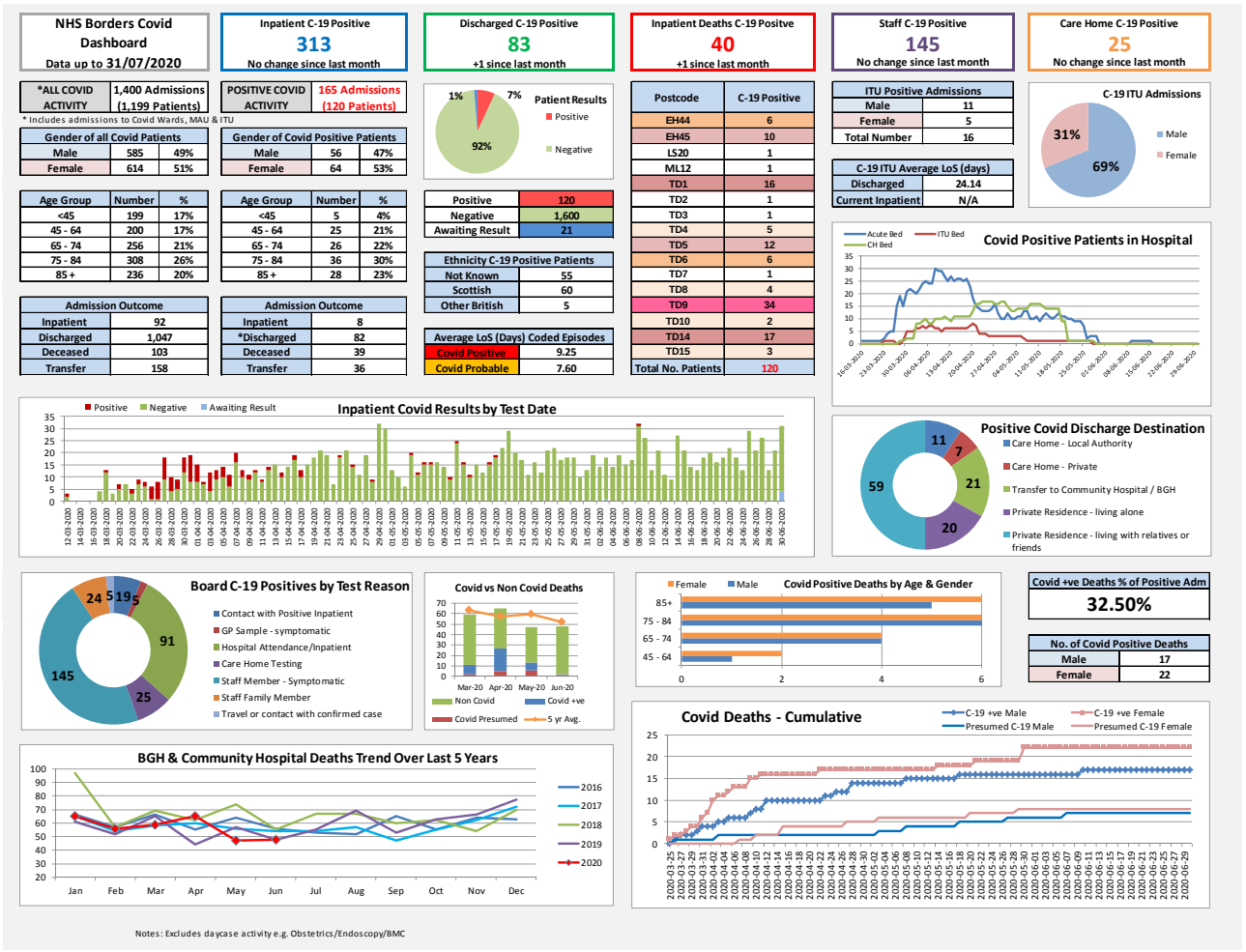
Early on during the COVID-19 period, we recognised the need to hear how staff were experiencing the positives and the challenges of coping with COVID-19. To do this, we have been working with OpenChange an external agency in a project titled 'Collecting Your Voices'. We have gathered contributions from a wide range of staff, through interviews, contributions, messages and posters with over 2,000 themes and comments.

As our "collecting voices" project feedback is analysed we will add key points to the lessons learned. We have been asked through various agency groups to contribute to formal debriefing exercises and will use the above points in doing so, but would welcome an overall and single route for lessons learnt across the whole of Scottish Government rather than a series of debrief requests which would detract capacity from our remobilisation activities.

Successes
NHS Borders is truly heartened by the response from its staff and the efforts that have been made, contributing to the following successes;

- Setting up a Deployment Hub and successfully deploying a significant number of staff across the organisation; in particular to COVID wards, the testing team and track & trace.
- Successfully setting up and coordinating a Transport Hub
- Mobilising a Sickness Absence Line
- Reconfiguring various clinical areas over a short period of time to support COVIDand non-COVID activity
- Successfully delivering urgent care throughout
- Here4u staff support service has been set up
- Increased pace to successfully provide a virtual clinic platform which has been well received by both patients and clinicians

The following pagesprovide NHS Borders data for the COVID-19 response.



Please Note: A pdf copy of this table is also included with the submission.

Latest Performance

Latest performance, which shows the impact of COVID-19 on standards from the Annual Operational Plan (AOP), is shown below.

Cancer Treatment:

Cancer treatment in terms of pathway progression has been largely unaffected as we continue to operate clinics and surgery for patients that are classified as Urgent and Urgent with a suspicion of cancer. There have been delays with some patients as there was a significant drop in referrals of around 70% each week. In addition to this, some patients have chosen not to come in for an outpatient appointment and there have been a few instances of this with the surgical patients for either shielding reasons or fear of COVID-19. Performance for July 2020 is detailed below:

- 100% of patients with a **Suspicion of Cancer to be seen within 62 days** were seen in time during July 2020.
- 100% of patients requiring **Treatment for Cancer to be seen within 31 days** were seen in time during July 2020.

Waiting Times:

The Recovery Planning Group (RPG) which was established in April continues to meet virtually on a weekly basis with representatives from across Health and Social Care, to co-ordinate a system wide response to our recovery.

Significant work has been conducted in order for us to safely recommence 50% of our pre-COVID-19 elective operating activity on 31st August 2020, with patients being asked to self isolate for 14 days prior to their operation. Work remains ongoing within the service to ensure this capacity is utilised to the greatest benefit including clinical prioritisation of patients and the review of which streams of patients need to self isolate for 14 days currently being undertaken. Due to the restrictive nature of our physical footprint in relation to safely managing COVID-19 and non COVID-19 patients an escalation plan has been produced which has specific trigger points agreed which would see a reduction in elective capacity if required.

A planned return of 40% of pre-COVID-19 activity for patients who need face to face outpatient appointments has now taken place. Where clinically appropriate patients are now being seen virtually and it is anticipated going forward that around 50% of outpatients appointments will be delivered virtually. The acute team continues to monitor this and work on a remobilisation plan aimed at increasing this level of activity is being produced, although the level of activity is unlikely to increase significantly as we plan for winter and the delivery of the flue vaccination programme.

The tables below demonstrate impact against agreed performance measures for both outpatient and inpatient waits and the amount of lost activity:

Outpatients:

Performance against agreed AOP trajectory:

	31/05/2020	30/06/2020	31/07/2020
Trajectory	100	100	100
Breaches	2055	2211	2146

Activity Lost per week:

	22/06/2020	29/06/2020	06/07/2020	13/07/2020	20/07/2020	27/07/2020
Variance	-1145	-1323	-1004	-635	-763	-1096
Cumulative Lost Outpatient Activity = 29387 appointments (new and review from 9th March – 31st July 2020)						

Inpatients:

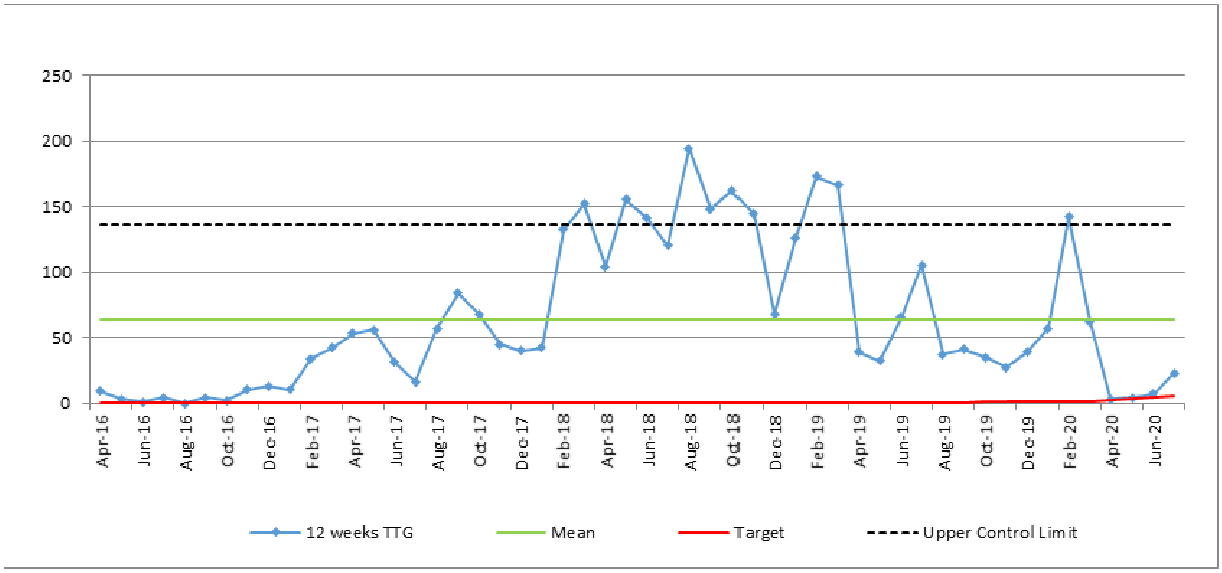
Performance against agreed AOP trajectory:

	31/05/2020	30/06/2020	31/07/2020
Trajectory	107	125	133
Breaches	894	1073	1069

Activity Lost per week:

	22/06/2020	29/06/2020	06/07/2020	13/07/2020	20/07/2020	27/07/2020
Variance	-59	-108	-97	-71	-36	-46
Cumulative Lost Inpatient/ Day Case Activity = 1612 (new and review from 9th March – 31st July 2020)						

TTG

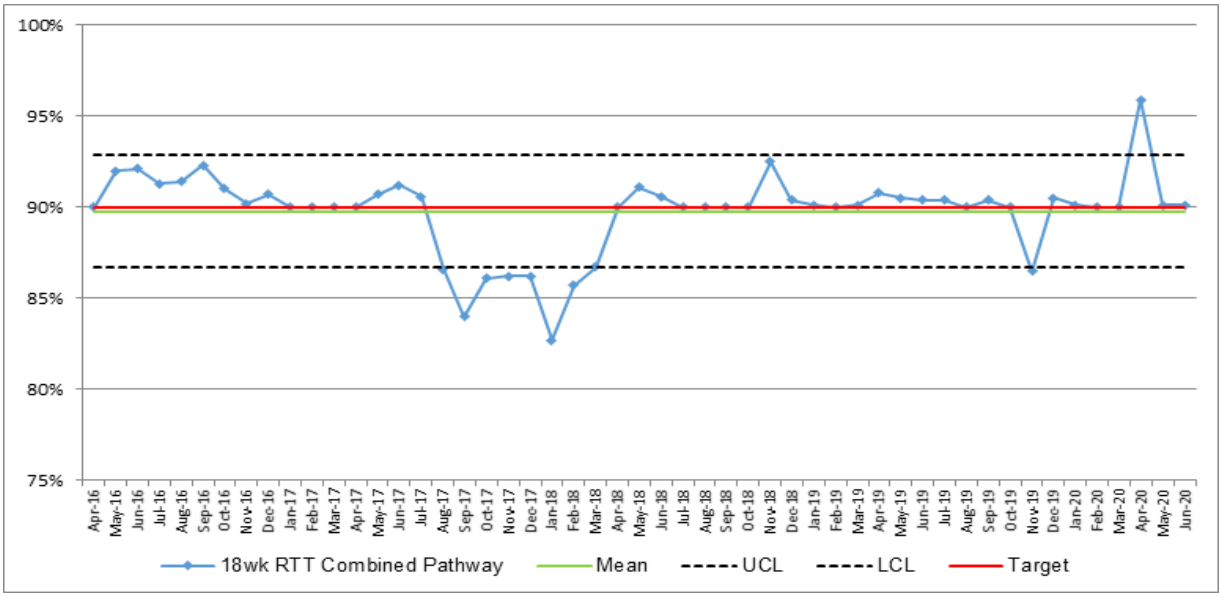


In response to the COVID-19 pandemic, NHS Borders ceased all non-urgent surgery which resulted in increasing waits for surgery and a reduction in the number of patients treated on a TTG pathway as indicated above. This resulted in cancellations of elective operating lists and planned weekend operating lists utilising independent sector staffing.

The Board was on schedule to achieve the trajectory provided to the Scottish Government by the end of March 2020 however due to the pandemic, this was not achieved and resulted in 197 patients reported as breaching their respective 12 weeks Treatment Time Guarantee date as of 31st March 2020. This was above the agreed trajectory of 100 patients over 12 weeks for the same time period.

Whilst non-urgent operating was suspended, the Board has maintained Urgent and Emergency operating throughout our COVID response and remobilisation.

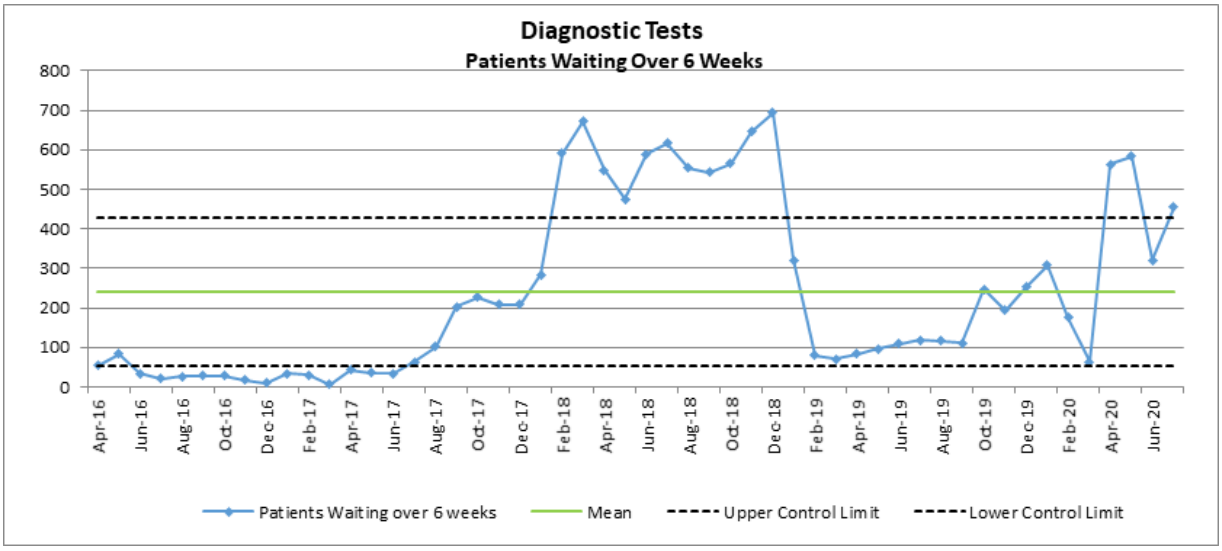
18 Weeks



The 18 weeks RTT performance improved through the Pandemic due to only urgent Outpatient and Surgical patients progressing on pathways. This resulted in fewer patients reported as completing their waits at the end of each month and an improving performance.

This however is predicted to reduce significantly following the phased restart of Outpatients and elective operating which will begin by appointing the longest waiters of which the majority are over 18 weeks at their first appointment. It is also anticipated that the Board will not achieve the 18 Weeks Referral to Treatment target of 90% until the backlog of waiters has been cleared.

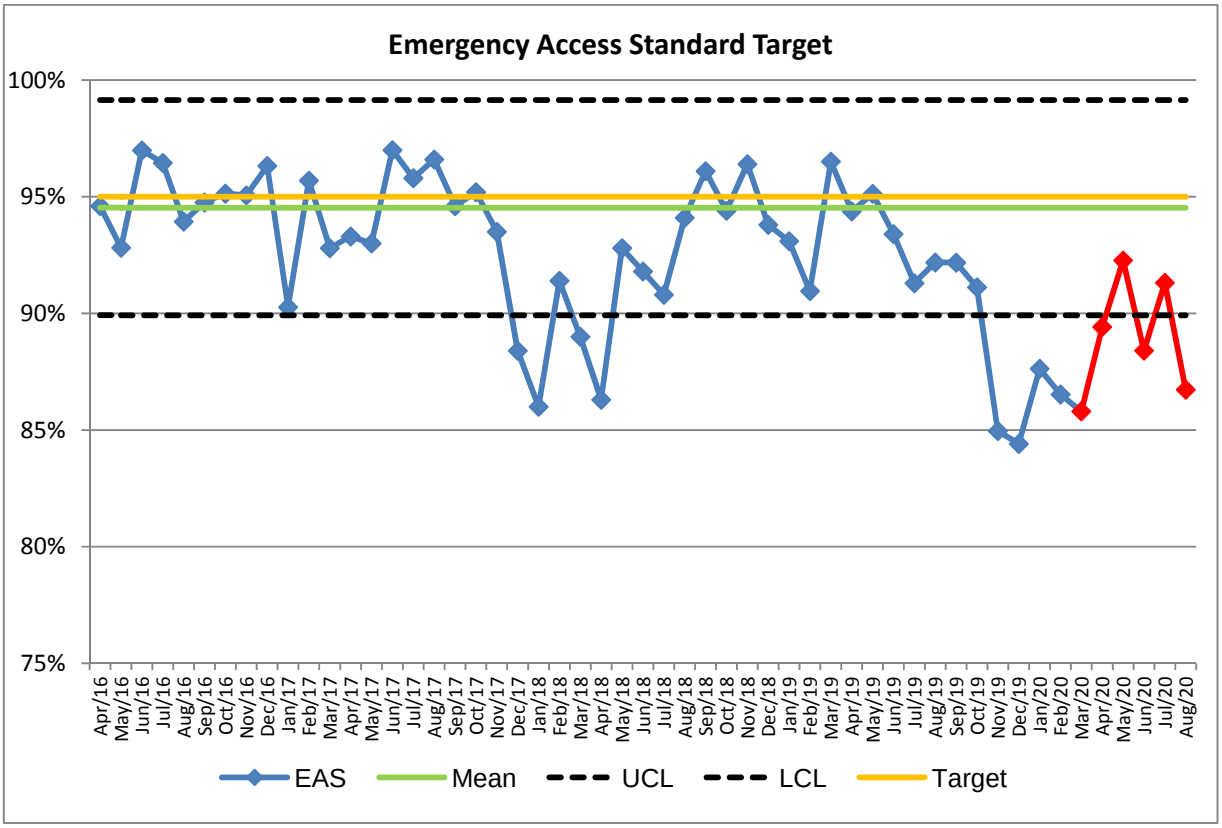
Diagnostic WT



Routine scanning activity was suspended in March 2020, however Urgent activity has continued without interruption. From late June clinically prioritised non-urgent activity recommenced. The reduced capacity during March – August has required the need to only scan clinically prioritised patients; this has resulted in a significant percentage of patients who were considered 'routine' when their referrals were received in February / March to be no longer considered as such. It is anticipated that it will be possible to see a maximum of 20-25% of patients who would previously considered routine within the new overall 60% Diagnostic capacity of pre-COVID-19 activity.

A&E 4 Hour Target

The graph below demonstrates performance in relation to the 4 Hour Emergency Access Standard, with the COVID-19 period highlighted in red:



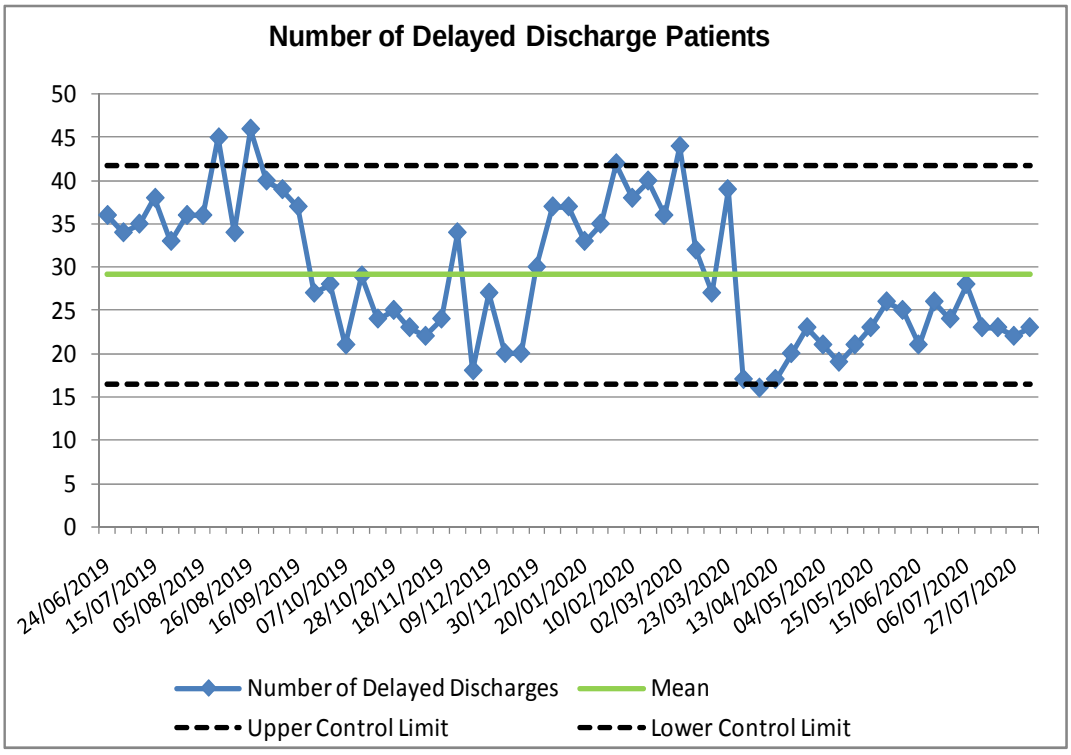
While the Emergency Department has embraced different ways of working this hasn't come without significant challenges as we have seen ED attendances increase to pre COVID-19 activity (and above). The Scottish government initiative to transform and Reshape Urgent Care is being taken forward in phases and we are working through the pathways of scheduling patients and re routing to the appropriate services. This will reduce the footfall through the Emergency Department. The development and testing of minor injuries pathway is being progressed.

Delayed Discharges

Delayed discharge performance (which includes Mental Health delays), against the target of no standard cases over 3 days is shown in the table below:

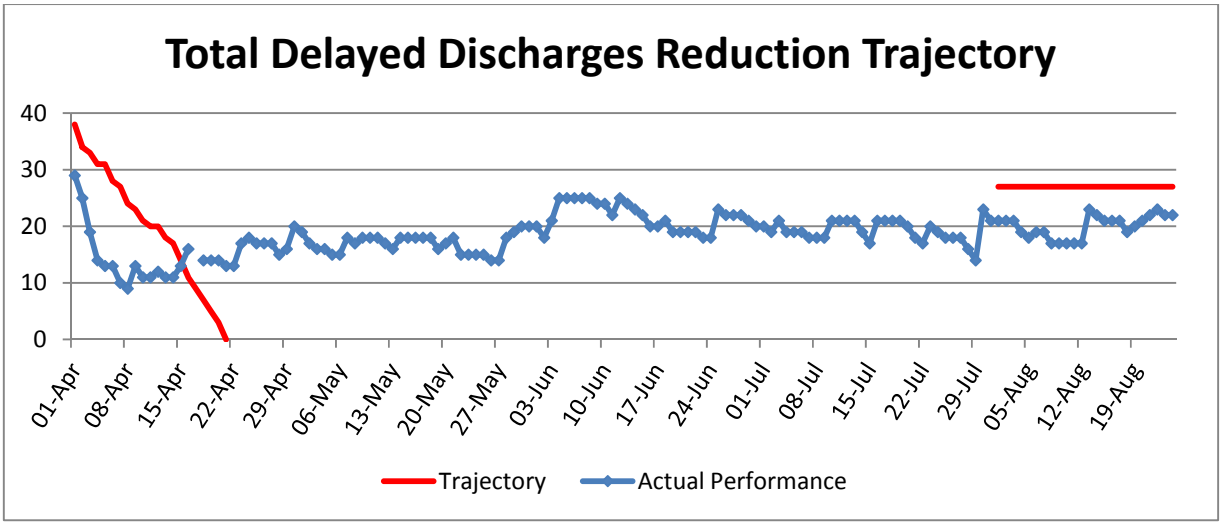
Standard	Apr-20	May-20	June-20	July-20
DDs over 2 weeks	5	10	8	10
DDs over 72 hours (3 days)	12	13	16	14
Occupied Bed Days (standard delays)	418	579	641	674

Since the 18th March 2020 there has been a sustained effort to reduce Delayed Discharges to as close to zero as possible to urgently free up bed space. The chart below shows that the weekly totals for the number of delayed discharges across the system decreased between the 16th March and the week commencing 13th April 2020but started to increase again through May.



As part of the Mobilisation Plan submitted to Scottish Government a trajectory to reduce Delayed Discharges to 0 by 21st April 2020 was included which was not achieved. A revised target for March 2021 has been submitted to Scottish Government, which proposes that there will be a 30% reduction in delayed discharges achieved by this time, which equates to no more than 20 delayed discharges.

NHS Borders is working closely with our partners at the Scottish Borders Council and the IJB on programmes specifically designed to reduce patients delay, increase flow and reduce the number of occupied bed days due to delays. Within the three clinical boards Integrated huddles have been established daily to concentrate on patients who are medically fit for discharge as well as those who are delayed in the system. This multi-disciplinary approach has meant that patients and complex discharges can be discussed with the relevant agencies to enable people to move on to their next care destination in a safe and timely manner. The chart below demonstrates our position at the time of writing this report:



Please Note: The trajectory was reduced to zero during the COVID-19 pandemic, however was reintroduced in August 2020 to focus on achieving the standard.

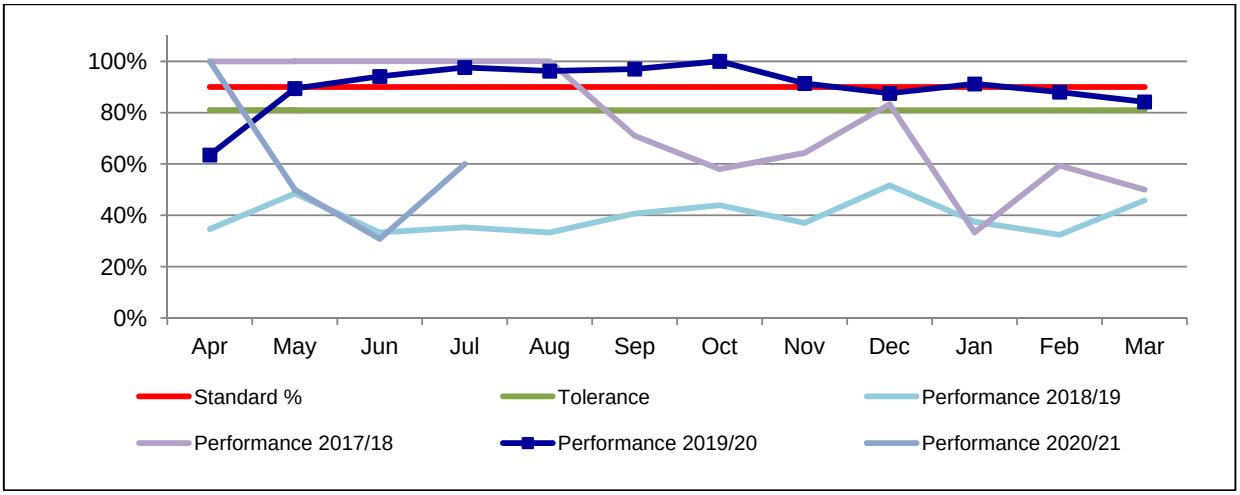
Type of Delayed Discharge	As at 04/06/2020	As at 02/07/2020	As at 06/08/2020
Standard Cases	20	27	24
Complex Cases	5	5	2
Total	**25**	**32**	**26**

During the COVID-19 response the admission criteria for the Intermediate care bed facilities were relaxed to increase bed capacity. A dormant facility was opened to provide additional nursing home beds within the system. These allowed a model of *Discharge to Assess* to be implemented.

The Partnership is currently strengthening the *Moving on Policy* to ensure full implementation and compliance. This will be rolled out in conjunction with an Educational approach. The Partnership will also focus on lessons learned from the COVID-19 response to ensure successful elements are taken forward.

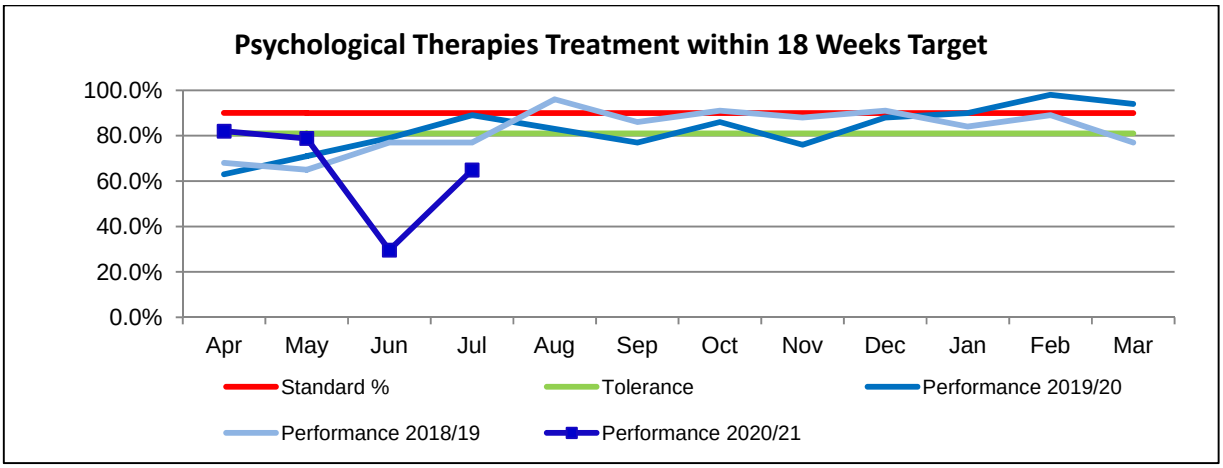
Child and Adult Mental Health Service

Pre-COVID CAMHS was performing at approximately 90% against its RTT target. The impact of COVID-19 has significantly, adversely impacted upon its ability to assess and treat patients. In relation to autism and neuro developmental assessments it has stalled its ability to do so altogether due to the need for direct observations. The number of people waiting has increased to 170, and of those approximately 2/3 are waiting in excess of 18 weeks. We are looking at introducing a waiting list initiative and redesigning our processes as part of our mobilisation plans.



Psychological Therapies

Although Psychological Therapy interventions were impacted at the start of the pandemic, the situation has subsequently improved. Near Me has been widely available and once suitable environments to deliver the clinical interventions were identified we have been able to resume to a significant level our delivery of assessment and treatment. A further impact was and continues to be the redeployment of staff to deliver staff support and increased support to our Well Being service. The latter being in response to COVID-19 related referrals from Primary Care.



SECTION 3: FORWARD LOOK

Looking Forward

- Remobilising our Financial Turnaround Program is a priority for the Board
- Revisiting and reprioritisation of the current Capital Programme for 2020/21
- Revisiting and reprioritisation of the current IM&T Road to Digital Programme for 2020/21

SurvivingWinter

Pressures of winter
The pressures we face every year over the winter period will be significantly more challenging with the need to retain COVID-19 capacity and flex the system as and when required.

Flu season
There is significant additional workload placed upon the Health Board to provide influenza vaccines out with GP practices. The eligibility for theinfluenza vaccination has been broadened to include those aged 55-64 which creates an additional workload. In addition, there is a need to ensure staff and eligible members of the public are aware of this and the revised routes to vaccination.We are currently actively planning the expanded 2020/21 influenza vaccination programme, and have allocated additional support to ensure successful delivery of the programme.

Key pressures with continued COVID response

Financial Impact
Since the establishment of the local remobilisation group in May 2020 a number of Board-wide proposals for remobilisation have been brought forward. Some of these proposals have been in relation to extending initial COVID-19 mobilisation (response) arrangements whilst others relate to activity required to remobilise services.To date, Gold Command has approved £1.949m of plans across all business units of the Board. This is the projected cost to 31 March 2021 and any extension of approved activity will be a cost pressure to the Board next financial year. In addition, a number of further plans are still being developed which if they were all to be approved would cost an additional £2.142m bringing the total to £4.091m.

Workforce
COVID-19 functions require an estimated 120wtestaff in order to fully deliver the required services. External recruitment exercises are underway in order to secure these staff for the next 12 months which would reduce / remove the need for staff deployed from other services. However it is unlikely that we will be able to source all of these additional staff. As a result contingency arrangements are being considered which include retaining staff currently deployed into these functions from other areas. The impact of this on our other services will be assessed as part of this work, and any final decisions will be informed by a clinical prioritisation process.

General Practice
An extensive Estates programme is currently underway to improve community buildings with regards to infection control and availability of space. The plan was approved by Gold Command in August and is now operational. A total of 101 activities are on the plan which includes hand gel, signage, vinyl, blinds, trunking and chairs, across 21 community buildings. Half of these activities are currently in progress.

ITU
Since the restart of elective surgery on 31st August, we require the critical care capacity for 4 streams of patients, ideally with these kept separate from one another to reduce risk transmission of COVID-19. During the first wave of in April we managed to contain COVID-19 patients within the main ITU and non-COVID patients in the recovery area of theatre. This was only successful because we had small numbers of non-COVID ITU patients at the time and there was not a requirement to treat surgical cancer patients as a separate group. In order to continue to deliver elective surgery and continue to look after all patients in need of critical care, in the event of admission of COVID-19 patients to BGH, an escalation plan has been developed by the Elective Theatre Recovery Group. This has been driven by clinicians. Within a small DGH this does create a level of fragility to our Elective capacity if COVID ITU admissions increase.

Emergency Department
As part of COVID-19 mobilisation plan NHS Borders expanded the ED footprint into the adjacent orthopaedic outpatient department and plaster room. This was to allow ED to effectively run as two different ED areas to separate COVID-19 (or suspected COVID-19) patients. The extended footprint allows for increased cubicle space to support patient separation, social distancing and infection prevention and control. Recognising the reduction in ED attendances since March lockdown, the ability to accommodate 3 additional pathways through the ED footprint has been achieved, noting over the last month there has been a steady move to preCOVID-19 numbers (and above) of attendees with significant pressures on the Emergency Access Standard (EAS). This will remain a challenge going forward.

Waiting Times backlog
In response to the COVID-19 pandemic, NHS Borders ceased all non-urgent surgery which has resulted in increasing waits for surgery. Across outpatient specialties and mental health services capacity was reduced which has resulted in a backlog of patients on waiting lists. A plan to address the back log of patients on waiting lists will be developed as we continue to remobilise. However at the current levels of reduced capacity for routine activity it is likely that the backlog will continue to grow in the short term.

Unmet Need
COVID-19 pandemic has far-reaching indirect consequences for the health of the population due to changes in economic and social circumstances, impact on mental wellbeing, changes in health related behaviours and disruptions in health and social services. There is likely to be an increased population health loss both now and in the future, as patients may present later with more severe disease which will be harder to treat. In addition there is likely to be widening of inequalities in health.

SECTION 4: ACF and APF

Area Clinical Forum

Pre-COVID-19
Pre-COVID-19, Area Clinical Forum was challenged with clinical engagement in the light of financial pressures and the turnaround programme. Representation from professional advisory groups was not good and two meetings had been cancelled due to low attendance. Risks highlighted have been: lack of clarity of financial accountability; limited IT and data analysis teams; clinicians under great pressure with frontline work; and a management structure constantly needed to react to inevitable short terms pressures of the system. Pre-COVID-19 presentations centered on financial turnaround, savings targets and the 3 year financial plan as well as Primary Care Improvement Plan.

COVID-19 Response
February - July 2020: Area Clinical Forum met in June 2020 when Chief Executive, Ralph Roberts, presented the NHS Borders Recovery and Re-mobilisation Plan; discussing the next phase of the plan and asking for feedback from ACF. ACF spoke of the critical nature of flu vaccination plans and also requested that the professional advisory groups be included in the Clinical Prioritisation Group. ACF discussed access to PPE; primary care stock provided was poorer quality and fit than preferred. Requirement for education programme for nursing and care home staff working together. Different guidelines early in the pandemic led to challenges. Community Pharmacy reported that the service was badly impacted as they rushed to be able to fulfill prescriptions that were not always required in the greater numbers presented. Supervised opioid replacement therapy service was stopped: any consequences of this change to be risk assessed for patients who need to return to previous service.

Remobilisation
1. Nursing staff have reported on the positive experience of clinical supervision. This is not always standard practice for acute staff and the opportunity during COVID for supervision meant the staff felt valued and were having a positive impact on their practice. It has been proposed that this is taken forward.
2. Management of flu vaccines.
3. Ophthalmology reported that the emergency eyecare treatment centre at the BGH with local optometrists carrying out telephone triage and referring to the centre when necessary had worked fairly well but that there were occasions when information and guidelines were not circulated when they should have been causing delays in responses.
4. PPE – ensuring future access for independent contractors.
5. Psychology reported the success of the Wellbeing Service changes set up to help staff during COVID-19 in partnership with occupation health to help staff manage stress and other COVID-related issues – how could this be funded going forward?
6. Public engagement – what plans are there to continue and maintain engagement?
7. Use of Near Me – how to address the inequalities of patients requiring support - not having private space, learning disability or no access to technology.

Area Partnership Forum

Pre-COVID-19

The APF was immersed in updates and input into the Turnaround Programme for NHS Borders. We had local Partnership Leads and Employee Director at all levels of decision making to support these programmes. These programmes came with many challenges but through Partnership processes we resolved many of these issues although staff morale was a significant issue throughout.

COVID-19Response

Despite the morale of staff when the Pandemic hit our organisation all staff rose to the challenge and worked strongly together to deal with the implications of this.

As we planned for the pandemic we recognised the importance of agile decision making although it was very clearly agreed that this did not mean ignoring due process or organisational principles such as Partnership working with the trade unions. It was undoubtedly a challenge in relation to the amount of information requiring to be shared and the speed at which this needed to be done. Again Partnership Leads and Employee Director were involved in processes at local and area wide levels including silver and gold command meetings.

During this time Employee Director was asked to lead Staff Wellbeing Group which took responsibility for setting up a Psychological Wellbeing Hub as well as development of a staff wellbeing plan now kept updated and accessible on intranet. Policy and Conditions of Employment Subgroup of APF was the core group responsible for any policy messages or decisions including the responsibility for cascading and application of STAC decisions. Employee Director and Associate Directors of HR worked closely to achieve this. Engagement with Staff side was a key part of this success. Staff side established weekly meetings to discuss and agree these outputs as well as being a resource for managers to discuss decisions required, these initially were on teleconference until Microsoft Teams was established. Most meetings were cancelled and agreement that we would stop processes around Turnaround over this period.

All other meetings and work that fell under the APF were stopped temporarily but APF continued to meet initially by teleconference then established onto Microsoft Teams. These were opportunities for staff side and management to develop common understanding of what we as an organisation were facing but also opportunity to raise concerns. The most challenging concern across this time was around staff safety and PPE. We now have a PPE Committee which listens to staff side input and acts effectively to these issues in Partnership.

Remobilisation

This is a big challenge for NHS Borders and we continue to involve staff side now every two weeks and in APF to keep the membership involved in and updated on key issues and decisions. Key challenges in this period will be around supporting staff who agreed as a temporary measure to change their role but remobilisation has not been as quick as previous thought due to our workforce levels, service demands in testing, track & tracing, vaccinations for flu, community impacts and environmental safety issues. This means staff cannot always return to their role as they expected without there being risk

to services (new) that are still required. This in staff side view creates a challenge around whether or not this is still voluntary and we feel should be discussed at STAC to consider further advice at Scottish Level.

The APF recognise that there are risks to communities and patients regarding the pace at which the core services are being remobilised particularly for those with Mental Health issues. The challenge is often a workforce resource issue for us and meeting very quick expected turnaround to set up and deliver.

We have re-established the OH Forum and the Equalities Committee and re-establishing on case by case basis ER casework.

Questions that Staff side are now asking:

1. In light of the pandemic and its continuing impact on health boards how will boards be financially supported at this time and going forward?
2. Will our previous board deficits prior to COVID-19 by written off or reduced to allow boards to focus solely on the current crisis. If not, why not?
3. Nationally how are ministers going to fund the additional costs health boards have encountered in dealing with the pandemic? Will this burden be laid at the door of the Health Board?
4. Will ministers recognise the exceptional performance of workers across the NHS in dealing with the pandemic and the efforts they will still be making as the crisis continues and ensure that this is reflected in pay for 2021?
5. What support both mental and physical support is being put in place for health workers as the pandemic continues?